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## NOTE

### Health Courts: An Extreme Makeover of Medical Malpractice with Potentially Fatal Complications

Emily Chow\*

#### INTRODUCTION

United States citizens spent \$5267 per capita on health care in 2002, nearly \$2000 more than any other country,<sup>1</sup> with annual spending reaching \$1.6 trillion.<sup>2</sup> Yet quality and availability of medical care continue to be concerns, and medical malpractice litigation is frequently blamed for rising consumer costs and skyrocketing physicians' malpractice premiums.<sup>3</sup> With physicians abandoning medical specialties with high malpractice premiums like neurosurgery,<sup>4</sup> and obstetrics-gynecology residencies reaching only 65% capacity for the medical school class of 2004,<sup>5</sup> there is a growing consensus within the medical

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1. Gerard F. Anderson et al., *Health Spending in the United States and the Rest of the Industrialized World*, 24 HEALTH AFF. 903, 904 (2005).

2. Katharine Levit et al., *Health Spending Rebound Continues in 2002*, 23 HEALTH AFF. 147, 148 (2004).

3. Ceci Connolly, *Malpractice Situation Not Dire, Study Finds*, WASH. POST, Mar. 10, 2005, at A8 (reporting that President George W. Bush, the American Medical Association, and some scholars believe lawsuits and large jury awards "have forced malpractice premiums to historically high levels"); Mark Moran, *Malpractice Liability Cap Fails in Senate*, PSYCHIATRIC NEWS, Aug. 1, 2003, at 1.

4. Joe Fahy, *Neurosurgeons Flee High Insurance Costs*, PITTSBURGH POST-GAZETTE, Mar. 26, 2006, at A13.

5. Press Release, Nat'l Resident Matching Program, Record Number of Applicants Matched to Residency Programs (Mar. 18, 2004), <http://www.aamc.org/newsroom/pressrel/2004/040318>

community that current efforts to resolve the “medical malpractice crisis” are failing.<sup>6</sup> The debate has spawned a variety of actions, including implementing noneconomic damage caps,<sup>7</sup> physician walkouts,<sup>8</sup> and the firing of a hospital staff member whose spouse’s law firm had a malpractice group.<sup>9</sup> A surgeon from South Carolina has even attempted to obtain the American Medical Association’s (AMA) support for his grassroots approach of refusing treatment to malpractice lawyers, their families, and their employees: “[it is] analogous to hitting the lawyers with a 2-by-4. Now we have their attention. Now maybe we can make some progress.”<sup>10</sup>

In fact, there has not been much progress in medical malpractice reform, especially as compared to the technological advancements in medicine over the last thirty years.<sup>11</sup> Malpractice became “medicine’s most serious crisis” for the first time in 1975, when many commercial insurers struggled to provide adequate coverage for physicians.<sup>12</sup> Despite the cyclical onset of several of these crises,<sup>13</sup> the traditional tort system remains the primary tool for victims of malpractice seeking compensation.<sup>14</sup>

The AMA has designated seventeen states as being in a full-blown medical

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.htm (noting that, despite a 5.3% increase in participation from 2003 levels, only 65.1% of the obstetrics-gynecology residency positions were filled). Since then, the interest in obstetrics-gynecology has increased: “[Ninety-eight] percent of these positions were filled [in 2006], 72 percent by U.S. medical school seniors.” Press Release, Nat’l Resident Matching Program, More U.S. Medical School Seniors Choose Residencies in Competitive and “Lifestyle” Specialties (Mar. 16, 2006), <http://www.aamc.org/newsroom/pressrel/2006/060316.htm>.

6. See Michelle M. Mello et al., *The New Medical Malpractice Crisis*, 348 NEW ENG. J. MED. 2281, 2284 (2003) (“[M]ost expect the malpractice crisis to deepen and spread even in the face of aggressive tort-reform efforts at the state and federal levels.”); Common Good, *An Urgent Call for Special Health Courts: America Needs a Reliable System of Medical Justice* (2005), <http://cgood.org/assets/attachments/130.pdf>.

7. See, e.g., Press Release, Wis. Office of the Governor, Governor Doyle Signs Assembly Bill 1073 (Mar. 22, 2006), [http://www.wisgov.state.wi.us/journal\\_media\\_detail.asp?locid=19&prid=1842](http://www.wisgov.state.wi.us/journal_media_detail.asp?locid=19&prid=1842) (reporting the implementation of a new higher noneconomic-damage cap in Wisconsin).

8. *AMA Chief, Professor Square Off on Blame for Malpractice Crisis*, 33 MOD. HEALTHCARE 52 (2003) (reporting the reactions of AMA president-elect Donald Palmisano and Professor Jonathan Turley to a physician walkout in West Virginia). Turley accused the doctors of “medical terrorism.” *Id.* According to Turley, “These latest walkouts are nothing short of hostagetaking: demanding huge benefits in exchange for basic medical care for captive patients.” *Id.*

9. Laura Parker, *Medical-Malpractice Battle Gets Personal*, USA TODAY, June 14, 2004, at 1A.

10. *Id.*

11. William M. Sage, *Medical Malpractice Insurance and the Emperor’s Clothes*, 54 DEPAUL L. REV. 463, 463 (2005).

12. *Id.* at 469.

13. *Id.* at 469-70.

14. See James C. Mohr, *American Medical Malpractice Litigation in Historical Perspective*, 283 JAMA 1731, 1736 (2000) (“[N]otwithstanding some movement in recent decades toward special judicial panels . . . the nation’s commitment to the ultimate mechanism of the ordinary jury is . . . likely to remain unshakably in place.”).

liability crisis because “the nation’s out-of-control legal system is forcing physicians . . . to retire early, relocate or give up performing high-risk medical procedures,” effectively preventing patient access to medical care.<sup>15</sup> Numerous studies link physicians’ fear of litigation and higher insurance premiums to their practice of “defensive medicine”<sup>16</sup> and the avoidance of high-risk specialties to qualify for less expensive liability insurance.<sup>17</sup> Some commentators worry that the rising malpractice costs will force physicians to stop practicing altogether, jeopardizing the availability of health care in some areas of the country.<sup>18</sup> Despite endorsement from the AMA, over fifty other physician, insurance, and patient organizations, as well as President George W. Bush, legislation proposing to limit malpractice liability has consistently failed to pass through Congress.<sup>19</sup>

In an early 2005 speech advocating for the cap, President Bush stated that

[w]hat’s happening all across this country is that lawyers are filing baseless suits against hospitals and doctors . . . . So doctors end up paying tens of thousands, or even hundreds of thousands, of dollars to settle claims, out of court, even when they know they have done nothing wrong. When insurance premiums rise, doctors have no choice but to pass some of the costs on to their patients . . . . If you’re a patient, it means you’re paying a higher cost to go see your doctor.<sup>20</sup>

Meanwhile, researchers studying the alleged medical malpractice crisis in the

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15. Am. Med. Ass’n, AMA (Policy) Medical Liability Crisis Map, <http://www.ama-assn.org/ama/noindex/category/11871.html> (last visited May 3, 2007).

16. “Defensive medicine is a deviation from sound medical practice that is induced primarily by a threat of liability. . . . [by] supplement[ing] care . . . , replac[ing] care . . . , or reduc[ing] care . . . .” David M. Studdert et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, 293 JAMA 2609, 2609 (2005). Although the prevalence of defensive medicine is difficult to quantify, *id.*, Common Good claims that doctors order “billions of dollars of unnecessary tests and procedures each year” in order to protect themselves from malpractice liability. Common Good, *supra* note 6, at 2.

17. See, e.g., Katherine Baicker & Amitabh Chandra, *Defensive Medicine and Disappearing Doctors?*, REG., Fall 2005, at 24, 30; Studdert et al., *supra* note 16, at 2616.

18. See Common Good, *supra* note 6, at 8 (“Unreliable justice is driving good ob-gyns out of practice, scaring medical students away from obstetrics and gynecology, and leaving women across the nation without prenatal and delivery care.” (quoting Vivian M. Dickerson, President, Am. Coll. of Obstetricians & Gynecologists)); Charles Hurt, *Edwards’ Malpractice Suits Leave Bitter Taste*, WASH. TIMES, Aug. 16, 2004, at A1 (“As a result of [malpractice] cases, insurance rates have skyrocketed—putting some out of business and driving others away, especially from rural areas.”). But see CONG. BUDGET OFFICE, LIMITING TORT LIABILITY FOR MEDICAL MALPRACTICE 1 (2004); Baicker & Chandra, *supra* note 17, at 29 (concluding that “there is little evidence of a mass exodus of physicians in response to increases in malpractice liability” upon analysis of empirical data). The General Accounting Office substantiated reduced access to emergency surgery and newborn delivery “in scattered, often rural, areas where providers identified other long-standing factors that affect the availability of services,” but it determined that high malpractice premiums “did not widely affect access to health care.” CONG. BUDGET OFFICE, *supra*, at 7.

19. See, e.g., Moran, *supra* note 3, at 1.

20. Connolly, *supra* note 3.

President's home state of Texas, one of the AMA's crisis states, found a sea of calm and reported that "at least in Texas, the tort system can't be the cause of spikes in malpractice premiums."<sup>21</sup>

Despite Bush's characterization of the malpractice crisis, the upward trend of litigation and damage awards does not directly correlate to the steady rise in malpractice premiums.<sup>22</sup> In July 2005, the Wisconsin Supreme Court found a ten-year-old noneconomic damage cap of \$350,000 to be unconstitutional, "unreasonable and arbitrary because it [was] not rationally related to the legislative objective of lowering medical malpractice insurance premiums."<sup>23</sup> In overturning the cap, the court cited various Wisconsin Office of the Commissioner of Insurance Reports on the statute, which "indicate[d] that a number of factors affect malpractice premium insurance rates, and that . . . 'no direct correlation [could] be drawn between the caps enacted in 1995 and current rate changes taking place in the primary market today.'"<sup>24</sup> Amidst the ongoing controversy over the effectiveness—and even constitutionality—of inconsistent reforms among different states, some advocates are now seeking a long-term solution through structural alteration of the traditional medical malpractice system in the form of health courts to hear malpractice cases.<sup>25</sup>

Like other courts in areas such as tax and bankruptcy, health courts would take the decision-making process away from juries and instead leave determinations up to a panel of expert judges.<sup>26</sup> According to Philip K. Howard, Chair of Common Good—a nonpartisan tort reform organization seeking to implement health courts—"the goal is to have deliberate rulings . . . so that doctors know where they stand because standards of care will be judged by people with expertise in the medical field."<sup>27</sup> To regulate the distribution of compensation under the health court model, Common Good has proposed the use of a rate schedule to normalize the amount of damages awarded for various

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21. *Id.* (quoting one of the study's co-authors, Professor David A Hyman). After analyzing about fifteen years worth of medical malpractice claims from Texas, researchers determined that "[n]o sudden rise in claim frequency, payments, defense costs, or jury verdicts preceded or accompanied the premium spike that occurred in Texas after 1998." Bernard Black et al., *Stability, Not Crisis: Medical Malpractice Claim Outcomes in Texas, 1988-2002*, 2 J. EMPIRICAL LEGAL STUD. 207, 255 (2005). See Am. Med. Ass'n, *supra* note 15 (citing Texas as a "great example" of a state enacting significant reforms and improving its "liability climate").

22. Sage, *supra* note 11, at 470.

23. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 468 (Wis. 2005). Following *Ferdon*, Wisconsin passed a new noneconomic damage cap of \$750,000. Wis. Office of the Governor, *supra* note 7.

24. *Ferdon*, 701 N.W.2d at 470-71 (quoting the Wisconsin Office of the Commissioner of Insurance report on the impact of the 1995 cap).

25. Michael Romano, *Trial and Error: Medical Courts, Arbitration Systems Are Among the Ideas Gaining Attention As Answers to the Malpractice Liability Crisis*, 33 MOD. HEALTHCARE 26, 26 (2003).

26. *Id.*

27. *Id.*

injuries and a 20% cap on trial-lawyer contingency fees to ensure that the victim is the one who is actually compensated.<sup>28</sup> Without the expenses of educating a lay jury and the threat of multimillion-dollar damages, the health court model would in theory lower the cost of litigating a malpractice claim, and its proponents assume that lower litigation costs translate to lower liability insurance premiums and health care costs.<sup>29</sup>

Proponents also believe that health courts would be more equitable for injured patients by preventing trial lawyer screening for “jackpot justice” (that is, the practice of only accepting sympathetic cases with the promise of large payouts).<sup>30</sup> Without this financially driven filter, so the argument goes, more victims with less severe injuries could gain access to the courtroom. Health courts could also benefit physicians by taming the soaring cost of malpractice insurance often attributed to the unpredictable application of medical standards by overly compassionate juries.<sup>31</sup>

There are, however, many unanswered concerns associated with such an extreme makeover of the traditional tort scheme. Critics claim that health courts would deprive injured victims of the right to be heard by fellow citizens considered so sacrosanct by the founding fathers.<sup>32</sup> Employing these specialized tribunals to discipline negligent doctors undercuts the notion of community standards by charging a select group of similarly trained individuals with the task of compensating malpractice victims.<sup>33</sup> Moreover, there exists a high risk of politicization of the health court’s bench, given the financial stakes that insurance companies, defendant physicians, trial lawyers, and plaintiff victims all have in medical malpractice litigation.<sup>34</sup> Most significantly, while the use of health courts may lower the transactional costs of each individual claim, the net effect of lowering the transactional costs is the invitation of more claims that victims would otherwise not file under the high transactional costs of the current system. It is unclear how a limited number of health courts would be able to handle this increased burden and how the malpractice insurers would respond.

28. Common Good, *supra* note 6.

29. *Id.* (“Fear of lawsuits makes it almost impossible even to talk about containing costs.”).

30. Philip K. Howard, Chair, Common Good, Address at the Annual Meeting of the American Medical Association’s House of Delegates (June 17, 2003), *available at* <http://cgood.org/healthcare-reading-cgpubs-speeches-8.html>.

31. Romano, *supra* note 25, at 26.

32. *Id.*

33. Kristin Eliasberg, *Malpractice Fix: Everyone Wants To Untangle the Medical Malpractice Mess—But Balancing Justice and Medicine May Be a Risky Procedure*, BOSTON GLOBE, Aug. 21, 2005, at E1 (“[Relying on a jury in medical malpractice cases] seems better than relying on an elite group who all have similar training and biases that go along with that training—whether in law school or medical school.”) (quoting Professor Nancy Marder, Chicago-Kent College of Law).

34. Catherine T. Struve, *Improving the Medical Malpractice Litigation Process*, 23 HEALTH AFF. 33, 37 (2004) (comparing the issue of politicization in health courts to the diffusion of political pressures in the conventional tort system due to a large number of judges hearing a variety of cases).

Despite protests from trial lawyers across the country,<sup>35</sup> the idea of health courts surfaced in Washington in the form of pending legislation, the Fair and Reliable Medical Justice Act of 2005.<sup>36</sup> Introduced for the second time by Senator Michael Enzi of Wyoming on June 29, 2005 (and cosponsored by Senator Max Baucus of Montana), the Act provides up to ten federal grants to interested states for “the development, implementation, and evaluation of alternatives to current tort litigation” in medical malpractice.<sup>37</sup> Each state pursuing a federal grant under the Act would be required to demonstrate how its alternative “(A) makes the medical liability system more reliable through prompt and fair resolution of disputes; (B) encourages the early disclosure of health care errors; (C) enhances patient safety; and (D) maintains access to liability insurance.”<sup>38</sup> The Act expressly suggests a “special health care court model,” as one of three enumerated possible alternatives.<sup>39</sup> The courts would give “judges with health care expertise” the authority “to make binding rulings on causation, compensation, standards of care, and related issues with reliance on independent expert witnesses commissioned by the court.”<sup>40</sup> The Act’s funding of these pilot programs is limited by “such sums as may be necessary. . . . [These funds] shall remain available until expended.”<sup>41</sup>

The bill has already garnered support across party lines and from both the medical and legal communities.<sup>42</sup> On June 22, 2006, the Senate Committee on Health, Education, Labor and Pensions held hearings on medical-liability proposals, including the Fair and Reliable Medical Justice Act.<sup>43</sup> *Congressional Quarterly HealthBeat* reported that health courts “attracted much attention . . . [with witnesses] divided on their merits.”<sup>44</sup> Howard was the third witness to testify at the committee hearing:

A court that writes opinions based on accepted medical standards not only holds the promise of overcoming the debilitating distrust [towards the current tort system], but can provide affirmative guidelines for improving care . . . . By

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35. See Eliasberg, *supra* note 33; Romano, *supra* note 25, at 26-27.

36. Fair and Reliable Medical Justice Act, S. 1337, 109th Cong. (2005).

37. *Id.* § 3(a)-(b).

38. *Id.* § 3(c)(2).

39. *Id.* § 3(d)(2)-(4).

40. *Id.* The bill itself does not define “health care expertise”; it only requires that health court judges “meet applicable State standards for judges and . . . agree to preside over such court voluntarily.” *Id.*

41. *Id.* § 3(k).

42. See Press Release, Common Good, Bipartisan Legislation to Create Special Health Courts Is Introduced in U.S. Senate (June 30, 2005), <http://cgood.org/healthcare-newscommentary-inthenews-241.html>.

43. See U.S. Senate Comm. on Health, Educ., Labor & Pensions, Hearings and Executive Sessions, [http://help.senate.gov/Hearings/2006\\_06\\_22/2006\\_06\\_22.html](http://help.senate.gov/Hearings/2006_06_22/2006_06_22.html) (last visited May 3, 2007).

44. Enzi Casts Wider Net for Solutions to Malpractice Compensation Woes, CQ HEALTHBEAT, June 22, 2006, available at [http://www.cmfw.org/healthpolicyweek/healthpolicyweek\\_show.htm?doc\\_id=378750](http://www.cmfw.org/healthpolicyweek/healthpolicyweek_show.htm?doc_id=378750).

restoring reliability to healthcare disputes, special health courts hold the promise of bringing order and good sense to the vital decisions needed for effective, safe and affordable healthcare in America.<sup>45</sup>

Despite the superficial appeal of health courts, however, these specialized tribunals may have detrimental effects on the cost of providing and obtaining health care, the efficiency of trials, and the equity of judgments. This Note compares the concept of health courts with the traditional tort regime to determine whether health courts could actually serve as a superior alternative in alleviating the malpractice crisis.<sup>46</sup>

Part I of this Note presents an overview of the Fair and Reliable Medical Justice Act of 2005 and the health court model as it has been marketed to the medical community. Part II compares the proposed model to the current malpractice litigation system in terms of equity of judgments, per trial and net transactional costs, efficiency of dispute resolution and victim compensation, liability insurance premiums, and health care costs. Part III examines the potential effects of employing health courts through case studies of nontraditional tort programs, including California's Medical Injury Compensation Reform Act arbitration provision, Wisconsin's medical mediation panels, and New Jersey's special mass tort courts.

This Note concludes that the risks associated with the implementation of health courts outweigh the few benefits they may provide over the traditional tort system. While health courts may increase courtroom access to more victims of medical malpractice and establish a uniform standard of care for physicians, they would also likely impose an immense net transactional cost, delay victim compensation, and drive up malpractice premiums without ensuring more equitable results or lowering the cost of health care. Employing a health court system would thus only aggravate the nation's health care problems. And in light of the curative effect of some existing reforms,<sup>47</sup> replacing the tort system with a specialized administrative court with uncertain consequences appears

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45. *Medical Liability: New Ideals for Making the System Work Better for Patients: Hearing Before the S. Comm. on Health, Education, Labor & Pensions*, 109th Cong. 11-12 (2006) (statement of Philip K. Howard, Chair of Common Good), available at [http://help.senate.gov/Hearings/2006\\_06\\_22/howard.pdf](http://help.senate.gov/Hearings/2006_06_22/howard.pdf).

46. This Note uses the term "malpractice crisis" to describe the subset of problems associated with the availability and affordability of liability insurance. See Mello et al., *supra* note 6, 2281-82.

47. CONG. BUDGET OFFICE, *supra* note 18, at 5. See, e.g., OFFICE OF TECH. ASSESSMENT, U.S. CONG., *IMPACT OF LEGAL REFORMS ON MEDICAL MALPRACTICE COSTS* 65 (1993) (summarizing the findings of six studies on total damage and noneconomic damage caps and concluding that damage caps generally reduced the size of malpractice claims and premiums); Kenneth E. Thorpe, *The Medical Malpractice 'Crisis': Recent Trends and the Impact of State Tort Reforms*, HEALTH AFF., W4-20, W4-26-27 (Jan. 21 2004), <http://content.healthaffairs.org/cgi/reprint/hlthaff.w4.20v1.pdf> (finding, in a comparison between states, that damage caps reduce malpractice premiums by 17.1% on average). See also *infra* text accompanying notes 312-26 (discussing potential methods of reforming the current system).



unwarranted and unnecessary.

# I. OVERVIEW OF HEALTH COURTS AS A RESPONSE TO THE MEDICAL MALPRACTICE CRISIS

The Fair and Reliable Medical Justice Act of 2005 embodies the frustration of physicians and health care consumers with the current state of medical malpractice and the intent of legislatures to respond with nontraditional alternatives.<sup>48</sup> Although the Act's section endorsing state experimentation with special health courts leaves much to the imagination, the legal reform organization, Common Good, has been lobbying for its own health court model,<sup>49</sup> which fits comfortably within the Act's loose framework.<sup>50</sup> The proposal materialized as a reaction to the medical malpractice crisis in the United States, and its proponents believe that it is a desirable alternative to the current litigation scheme.<sup>51</sup>

## A. *The Fair and Reliable Medical Justice Act of 2005*<sup>52</sup>

In 1932, Justice Louis Brandeis stated in a dissenting opinion that "[i]t is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country."<sup>53</sup> With pending legislation and the potential availability of federal grant money, states may soon be able to act as laboratories for an alternative to the current medical malpractice tort regime. Building upon a 2002 Institute of Medicine report advocating the use of state experiments in medical liability reform,<sup>54</sup> the Fair and Reliable Medical Justice Act of 2005 proposes to fund state experiments in tort reform to find a long-term solution to the medical malpractice crisis.<sup>55</sup>

In introducing the Act to Congress, Senator Enzi cited the 1991 Harvard Medical Practice Study, which found that less than 2% of those injured by

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48. See 151 CONG. REC. S7636-37 (daily ed. June 29, 2005) (statement of Sen. Enzi)

Clearly, the American people and their elected representatives have identified the need to reform our current medical litigation system. . . . [W]e ought to lend a hand to States that are working to change their current medical litigation systems and to develop creative alternatives that could work much better for patients and providers.

49. Common Good, *supra* note 6; see also Michelle M. Mello et al., "Health Courts" and Accountability for Patient Safety, 84 MILBANK Q. 459, 460-61 (2006).

50. See S. 1337, 109th Cong. § 3(d)(4) (2005).

51. See Common Good, *supra* note 6, at 4.

52. S. 1337.

53. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

54. Press Release, Max Baucus, Baucus Bill Seeks to Streamline Medical Malpractice Claims (June 29, 2005), <http://baucus.senate.gov/newsroom/details.cfm?id=252923>.

55. See S. 1337.

medical negligence actually brought a case to court, meaning that most cases of actual medical negligence were not litigated at all:

We like to say that justice is blind. With respect to our medical litigation system, I would say that justice is absent and nowhere to be found . . . No one questions the need to restore reliability to our medical justice system. But how do we begin the process? One way is to foster innovation by encouraging States to develop more rational and predictable methods for resolving healthcare injury claims. And that is what the Fair and Reliable Medical Justice Act aims to do. After all, the unfairness and unreliability of the current tort system seem to be supported by the fact that over ninety-eight percent of malpractice victims do not have their day in court.<sup>56</sup>

Although the Act would help finance any state program that “demonstrate[s] how the proposed alternative . . . makes the medical liability system more reliable through prompt and fair resolution of disputes; encourages the early disclosure of health care errors; enhances patient safety; and maintains access to liability insurance,” it explicitly approves the three models described in its text,<sup>57</sup> including the “early disclosure and compensation model,”<sup>58</sup> the “administrative determination of compensation model,”<sup>59</sup> and the “special health care court model.”<sup>60</sup>

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56. 151 CONG. REC. S7635 (daily ed. June 29, 2005) (statement of Sen. Enzi); *see also* A.Russell Localio et al., *Relation Between Malpractice Claims and Adverse Events Due to Negligence. Results of the Harvard Medical Practice Study III*, 325 NEW ENG. J. MED. 245, 247, 250 (1991) (concluding through the use of empirical data that “the civil-justice system only infrequency compensates injured patients and rarely identifies and holds health care providers accountable for substandard medical care”). The Harvard Medical Practice Study “identified patients who had filed claims against physicians and hospitals” in New York State in 1984 and compared those results to “the incidence of injuries to patients caused by medical management.” *Id.* at 245.

57. S. 1337, 109th Cong. § 3 (2005).

58. *Id.* § 3(d)(2). The Act’s “early disclosure and compensation model” requires health care providers to disclose incidents of medical negligence resulting in severe injury to the patient and provides those providers with the opportunity to offer good faith compensation of economic damages, noneconomic damages, and reasonable attorney fees for a limited time without subjecting them to tort liability. *Id.* § 3(d)(2)(A)–(D). This model expressly preserves “the right of an injured patient to seek redress through the State tort system if a health care provider does not enter into a compensation agreement with the patient.” *Id.* § 3(d)(2)(E).

59. *Id.* § 3(d)(3). The Act’s “administrative determination of compensation model” calls for a board to establish classes of avoidable injuries and for the state to modify tort liability to bar negligence claims in court against health care providers for those classes of avoidable injuries except in cases of fraud or criminal conduct. *Id.* § 3(d)(3)(A)(i). The board would resolve liability claims for the classes of avoidable injuries and determine compensation through the use of a schedule, which would consider economic damages, noneconomic damages, and reasonable attorney fees. *Id.* § 3(d)(3)(A)(ii). The model permits states to choose between three types of appellate review: de novo review, review with deference, or opportunity for the victim to reject the board’s determinations and seek civil action. *Id.* § 3(d)(3)(B).

60. *Id.* § 3(d)(4).

Far less developed than the other two suggested options, the Act's "special health care court model" only consists of five brief paragraphs.<sup>61</sup> The brevity is perhaps intentional, insofar as it permits various experimental spin-offs. The section requires interested states to "ensure that such court is presided over by judges with health care expertise who meet applicable State standards for judges and who agree to preside over such court voluntarily."<sup>62</sup> States must also allow the judges to make binding decisions on "causation, compensation, standards of care, and related issues with reliance on independent expert witnesses commissioned by the court."<sup>63</sup> The Act also instructs interested states to provide for an appeals process, but it does not offer any further guidance in ensuring adequate appellate review.<sup>64</sup> Additionally, the bill suggests optional use of an "administrative entity" comprised of state-licensing boards, patient-advocacy groups, health care providers, and trial attorneys—all of whom would act to oversee the special court.<sup>65</sup>

The Act's flexible structure would easily permit Common Good's health court model. In fact, Senator Enzi ostensibly borrowed the organization's stated mission of providing a more reliable system of medical justice for all Americans when he introduced the bill to Congress in 2005. Aimed at combating the "random justice" of inconsistent jury verdicts in medical malpractice cases and the high costs of health care in America, Common Good's health court concept boasts support from nearly ninety medical school deans and professors, university presidents, and politicians.<sup>66</sup> Even the *Economist* has agreed that Common Good's health court proposal appears to be a "sensible idea" to fight defensive medicine, restore access to health care for Americans, and compensate actual victims of medical negligence.<sup>67</sup> By selectively combining several reforms into one model, Common Good has created a superficially appealing solution to the problems associated with the current tort system—however, it is a solution that offers only limited improvements with significant setbacks.

### *B. Proposed Logistics of the Common Good's Health Court Model*

Phillip Howard has said that "[m]edical courts are a better system, there's no question about it."<sup>68</sup> The most developed and well-known plan for health courts

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61. *See id.*

62. *Id.* § 3(d)(4)(B).

63. *Id.* § 3(d)(4)(C).

64. *Id.* § 3(d)(4)(D). Common Good's proposal states that "[t]o assure uniformity and predictability, each ruling could be appealed to a new Medical Appellate Court." Common Good, *supra* note 6, at 4.

65. S. 1337, 109th Cong. § 3(d)(4)(E) (2005).

66. *See* Common Good, *supra* note 6.

67. *Scalpel, Scissors, Lawyer: Litigation and Health Care*, *ECONOMIST*, Dec. 17, 2005, at 51 [hereinafter *Scalpel, Scissors, Lawyer*].

68. Romano, *supra* note 25, at 26.

is Common Good's model, which replaces juries with a tribunal of judges with medical expertise gained through education or experience to establish a uniform standard of care.<sup>69</sup> The proposal circumvents the "dueling experts" phenomenon by soliciting testimony from a neutral expert selected by the health court judges. It also attempts to cut the cost of trial by imposing a 20% cap on attorney contingency fees.<sup>70</sup> The model includes a predetermined injury-specific rate schedule to normalize the distribution of noneconomic damages for any given injury from verdict to verdict.<sup>71</sup> While these four logistical elements may accomplish their express goals, their implementation would also threaten to aggravate the current malpractice crisis.<sup>72</sup>

### *1. Expert Judges Instead of Juries*

Howard has stated that one of the principal problems with the current tort system is that juries make particularized decisions about the standard of care, leading to inconsistent application from jury to jury.<sup>73</sup> Compounding the problem is that juries can award damages reaching tens of millions of dollars based on shaky merits.<sup>74</sup> In order to develop a uniform standard of care for physicians, the health court model abolishes the use of juries in medical malpractice cases and instead calls for review by full time judges who are "dedicated solely to addressing healthcare cases . . . [and] appointed through a nonpartisan screening commission."<sup>75</sup> These judges would have relevant background or gain expertise through handling medical malpractice cases exclusively.<sup>76</sup> Proponents argue that these judges would become more expert in the overlap of the medical and legal arenas and could establish precedents to guide doctors and patients on the proper standard of care.<sup>77</sup> Written rulings setting forth standard of care precedents would promote consistency across fact patterns.<sup>78</sup> To maintain the uniformity of

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69. *Id.*

70. Common Good, *supra* note 6; Mello et al., *supra* note 49, at 463 fig.1.

71. Common Good, *supra* note 6.

72. *See infra* Part II.

73. Philip K. Howard, Op-Ed., *Strong Medicine*, WALL ST. J., Jan. 6, 2007, at A6 ("[T]he civil jury was never supposed to decide standards of care as a matter of law . . ."). *See also* Eliasberg, *supra* note 33.

74. *See, e.g.*, Alastair MacLennan et al., *Who Will Deliver Our Grandchildren? Implications of Cerebral Palsy Litigation*, 294 JAMA 1688, 1689 (2005); Stephanie Reitz, *Hospital, Doctor Faulted: Boy Suffered Brain Damage During Birth*, HARTFORD COURANT, Nov. 29, 2005, at A1.

75. Common Good, *supra* note 6.

76. *See* Romano, *supra* note 25, at 26 ("Health court judges would be nominated by a board of qualifications, whose members would be appointed by the state. . . . The composition and appointment procedures for the board of qualifications are matters for state policymakers to decide but should be designed to ensure fairness and a balanced representation of stakeholders' interests."); Mello et al., *supra* note 49, at 464.

77. Mello et al., *supra* note 49, at 464.

78. Common Good, *supra* note 6.

judgments, any appeals would be reviewed by a new medical appellate court.<sup>79</sup>

This carving out of medical malpractice for adjudication by a specialized tribunal draws its legitimacy from the success of specialized administrative courts in other legal areas, like bankruptcy<sup>80</sup> and tax.<sup>81</sup> Certainly, the complexity of medical standards, procedures, and terminology is not unlike the complexity encountered in bankruptcy and tax proceedings, but the notion of removing the decision-making process from a jury has constitutional and equitable implications if done federally.<sup>82</sup> Currently pending health court legislation avoids involving the Seventh Amendment right to trial by jury guaranteed in federal courts by seeking implementation on a state level.<sup>83</sup> With the limited number of health court judges, however, even state health courts do not escape the inevitable politicization of the health court bench.<sup>84</sup> In such a highly polarized environment, the selection of judges—even if by “a nonpartisan screening commission”<sup>85</sup> or a “board of qualifications”<sup>86</sup>—could taint the fairness of trials. The judges would be the sole determiners of liability and hand-pick “neutral” experts from a predetermined pool selected by the same commission or board that appoints the judges.<sup>87</sup>

## 2. “Neutral” Experts

Called upon to educate the jury and the legal community on the appropriate

79. *Id.*

80. Although Article I of the Constitution expressly gives Congress the authority to create uniform laws on bankruptcy, U.S. CONST. art. I, § 8, cl. 4, the bankruptcy jurisdiction of federal courts is a relatively recent development. See Bankruptcy Reform Act of 1978, Pub. L. No. 95-598, 92 Stat. 2549 (1978), amended by Departments of Commerce, Justice, and State, the Judiciary, and Related Agencies Appropriations Act of 1984, Pub. L. No. 98-166, 97 Stat. 1071 (1984). The Bankruptcy Reform Act granted original bankruptcy jurisdiction to the district courts and instituted a bankruptcy court in every judicial district. *Id.*

81. Created by the Tax Reform Act of 1969 under Article I of the Constitution, U.S. Tax Courts only hear federal tax cases and issue regular and memorandum decisions. See Tax Reform Act of 1969, Pub. L. No. 91-172, 83 Stat. 730.

82. See *Duncan v. Louisiana*, 391 U.S. 145, 156-57 (1968) (“We are aware of the long debate, especially in this century, [as] to the wisdom of permitting untrained laymen to determine the facts in civil and criminal proceedings. [Most] of the controversy has centered on the jury in civil cases.”).

83. “Our recent work, conducted in partnership with . . . Common Good . . . , has led to a number of refinements of the proposal: most notably, the proposition that reform should begin with small-scale policy experiments.” Mello et al., *supra* note 49, at 460. See also Romano, *supra* note 25, at 26.

84. See *infra* Subsection II.B.2.

85. Common Good, *supra* note 6.

86. Mello et al., *supra* note 49, at 465.

87. *Id.* The board would make its selection “after soliciting applications from the medical community.” *Id.* To qualify as an expert in a given case, the witness “would have to be qualified in the same profession as the defendant . . . and in a clinical specialty relevant to the nature of the claim and to certify that he or she had no conflict of interest with respect to the case.” *Id.*

application of the standard of care in various situations, medical experts serve to clarify and reinforce the standard by testifying about matters in their sphere of medical expertise, exposing noncompliant physicians and protecting patients from harmful practitioners.<sup>88</sup> As such, expert testimony is the foundation of any medical malpractice case. Traditionally, each party has relied on their own medical expert to support its legal arguments, thus creating the perception that “dueling ‘hired gun’ experts . . . confuse and prolong disputes . . . .”<sup>89</sup> Although expert testimony is often necessary to explain the intricacies of medical procedures and treatment to juries, the phenomenon of dueling experts tends to undermine efficiency and accountability by lengthening trials and encouraging the jury to believe that medical knowledge and practice support both parties.<sup>90</sup>

The AMA’s Code of Medical Ethics requires that testifying medical experts “have recent and substantive experience in the area in which they testify and should limit testimony to their sphere of medical expertise . . . [without] becom[ing] an advocate or a partisan in the legal proceeding.”<sup>91</sup> Medical experts, however, are well compensated for their testimony,<sup>92</sup> and testifying for the winning party increases an expert’s marketability as a witness. While bad-faith testimony from medical experts may be rare,<sup>93</sup> an expert’s financial interest in

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88. See AM. MED. ASS’N, E-9.07 MEDICAL TESTIMONY, in AMA CODE OF MEDICAL ETHICS, available at <http://www.ama-assn.org/ama/pub/category/8539.html>.

89. Common Good, *supra* note 6, at 6. See also J.H. Beuscher, *The Use of Experts by the Courts*, 54 HARV. L. REV. 1105, 1105-06, (1941) (arguing that the use of “partisan experts . . . frequently operates to confuse the . . . jury rather than to inform”); Scott E. Sundby, *The Jury as Critic: An Empirical Look at How Capital Juries Perceive Expert and Lay Testimony*, 83 VA. L. REV. 1109, 1129-30 (1997) (“Interviews of jurors in . . . medical malpractice litigation . . . found jurors skeptical of the economic, medical, and actuarial experts who had testified.”).

90. See Sundby, *supra* note 89.

91. AM. MED. ASS’N, *supra* note 88. The AMA’s Council on Ethical and Judicial Affairs relies on findings of unethical conduct made by state medical societies and national specialty societies “to acquit, admonish, censure, or place on probation the accused physician or suspend or expel him or her from AMA membership . . . . However, the AMA is not in a position to take action against a physician’s license to practice medicine.” Am. Med. Ass’n, *Frequently Asked Questions in Ethics*, [http://www.ama-assn.org/ama/pub/category/5105.html#what\\_can\\_ama\\_do](http://www.ama-assn.org/ama/pub/category/5105.html#what_can_ama_do) (last visited May 3, 2007). State medical societies and licensing boards can begin professional reviews of physicians who violate the AMA’s Code of Medical Ethics. Am. Med. Ass’n, *AMA (Ethics) Reporting Ethical Violations*, <http://www.ama-assn.org/ama/pub/category/2509.html> (last visited May 3, 2007). State licensing boards can initiate legal action on the physician’s fitness to practice medicine. *Id.*

92. *Kirby v. Ahmad*, 635 N.E.2d 98, 99 (Ohio Com. Pl. 1994) (noting that “the Hippocratic Oath has been supplanted by opportunism and greed by those who participate as medical expert witnesses” and charge 500 to 750 dollars per hour); GERRY SPENCE, *WITH JUSTICE FOR NONE* 270 (1989) (“Some medical school professors . . . make several times their annual salary by selling testimony to anyone who will retain them.”); Douglas R. Richmond, *Expert Witness Conflicts and Compensation*, 67 TENN. L. REV. 909, 934 (2000) (“Treating physicians may charge expert witness fees much higher than regular patient rates, a practice criticized by reviewing courts.”).

93. Alexis Wood, *Professional Oversight of Expert Testimony*: Austin v. American Association of Neurological Surgeons, AM. MED. ASS’N J. ETHICS, Apr. 2005, available at <http://www.ama-assn.org/ama/pub/category/14859.html> (“While compensation will not buy bad

the outcome of the case can conflict with the obligation to advocate for the well-being of patients.<sup>94</sup> Ultimately, the cost in terms of time, money, and reliability associated with the use of dueling experts appears to undercut the accountability of the justice system in medical malpractice cases. Health courts resolve this issue by authorizing judges to select “neutral experts” in the relevant area of medicine, rather than listen to dueling experts hired by the two parties.<sup>95</sup> Still, in certain controversial areas of medicine, “neutral” experts may not exist, and the current adversarial nature of expert witness testimony may be desirable.<sup>96</sup> It is unclear how the health court judges would then decide which expert’s opinion to adopt as the standard of care. Despite these uncertainties, by abolishing the use of dueling experts, Common Good claims that health courts would be able to resolve most cases “within months” and “reduc[e] current costs by almost half.”<sup>97</sup>

### 3. A 20% Cap on Attorney Fees

Common Good’s proposal also seeks to maximize victim compensation by limiting attorney’s fees to 20%.<sup>98</sup> Malpractice attorneys typically operate on contingent fees, such that they are only paid upon settlement or victory in court.<sup>99</sup> These fees usually constitute one-third of any award, but malpractice contingency fees “are higher because [malpractice cases] are much riskier and require the investment of substantial[ly] more money and time than the average personal injury case.”<sup>100</sup> Because most malpractice attorneys operate on a contingent-fee basis (charging at least forty percent),<sup>101</sup> they maintain financial incentives to screen malpractice cases before providing representation, so as to turn the highest possible yield: “Pursuing litigation is costly for lawyers. They won’t lay out a bet unless they think they’ll win.”<sup>102</sup> Thus, cases with expected damages of less than \$200,000 are frequently turned down, leaving victims with less severe injuries uncompensated.<sup>103</sup>

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faith testimony from most physicians, having a financial interest in the outcome of the case can conflict with a physician’s obligation to put the well-being of patients foremost at all times.”).

94. AM. MED. ASS’N, *supra* note 88.

95. Romano, *supra* note 25, at 26.

96. See, e.g., *infra* Subsection II.B.1 (describing the lack of consensus within the medical community regarding the merits of electronic fetal monitoring in cerebral-palsy malpractice cases against obstetrician-gynecologists).

97. Common Good, *supra* note 6.

98. *Id.*

99. Alexander Tabarrok, *Give the Lawyer His Cut*, FORBES, Oct. 3, 2005, at 42.

100. The Cochran Firm, The Attorney’s Fee Contingency Fee, [http://www.cochranfirm.com/resource\\_detail.asp?id=4&resource=17&detail=70](http://www.cochranfirm.com/resource_detail.asp?id=4&resource=17&detail=70) (last visited May 3, 2007).

101. Romano, *supra* note 25, at 27.

102. Tabarrok, *supra* note 99.

103. Romano, *supra* note 25, at 26.

Common Good's proposal attempts to encourage the litigation of claims seeking lesser damages, by effectively lowering the litigation bar of \$200,000 through the lower cost per trial, and to put an extra 20% of damage awards in the victim's pocket, by capping contingent fees in malpractice cases at 20%.<sup>104</sup> This fee restriction would lead attorneys to modify client payment to maximize profits, causing a shift to an hourly rate or a significant increase in claims to make up for the reduced return in contingent fees.<sup>105</sup> Thus, the potential unintended effects of reducing the economic barrier to litigation could be the discrimination against those who cannot afford to pay upfront fees and the straining of the health court docket.<sup>106</sup> It remains uncertain whether the limited venues will be able to deal with the influx of claims that the current system weeds out, especially given the proposed shift from a compensation standard of negligence to one of avoidability.<sup>107</sup>

#### *4. An Avoidability Standard for Compensation and a Predetermined Noneconomic Damages Schedule*

In response to the inability of the current tort system to compensate patients who have suffered avoidable injuries, health court advocates have proposed relaxing the standard for compensation from negligence to avoidability.<sup>108</sup> "Avoidable adverse events are injuries that are (1) caused by treatment (or the omission of treatment) and (2) should rarely . . . occur when care is provided according to best practice."<sup>109</sup> By switching to an avoidability standard, the pool of potential claims would expand to include patients who suffered avoidable injuries not due to negligence.<sup>110</sup> Researchers have estimated the avoidability standard to allow twice as many potential litigants as the negligence standard.<sup>111</sup>

Damages awarded to successful plaintiffs in health courts would include economic damages (for medical costs and lost income)<sup>112</sup> and a predetermined

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104. See Common Good, *supra* note 6.

105. See *infra* Section II.C. It is possible that, despite the lower transactional cost per trial, attorneys may not be able to profit from litigating health court claims with the 20% contingent-fee cap; if this were the case, taking on more cases would not adequately sustain their income stream. Without the financial incentives that the current litigation system offers, attorneys may lose interest in litigating malpractice claims altogether, perhaps facilitating a more administrative version of health courts with pro se litigants. For purposes of discussion, however, this Note assumes that the twenty-percent cap on contingency fees will not force attorneys out of the malpractice equation.

106. See *id.*

107. See *id.*; *infra* Section III.B.

108. See Mello et al., *supra* note 49, at 466 (characterizing the avoidability standard as "occup[ying] a middle ground between the standards of strict liability . . . and negligence"); Howard, *supra* note 75.

109. Mello et al., *supra* note 49, at 466.

110. *Id.*

111. *Id.* at 467.

112. *Id.* Surprisingly, Professor Michelle Mello qualifies the full compensation of economic



sum to cover noneconomic damages for the particular injury, set by another panel of experts.<sup>113</sup> Because jury compositions and determinations vary by case, there is little consistency among awards of noneconomic and even economic damages.<sup>114</sup> A team of researchers from Common Good and the Harvard School of Public Health plans to propose a schedule for automatic compensation of noneconomic damages on an injury-specific basis to reimburse victims<sup>115</sup> “based on decision-science research about how the public values various utility losses and public deliberation about reasonable compensation.”<sup>116</sup> By removing the shaky calculus of jury negligence and award determinations, the intended consequence of this no-fault compensation would be twofold: quicker and more predictable victim compensation and prevention of medical errors for patient safety.

According to proponents of the rate schedule, “[health care providers would] be able to say, ‘If this happens, we pay, no matter what,’” thus providing quicker payouts to injured patients,<sup>117</sup> especially those with less severe injuries who are left uncompensated due to the trial lawyer screening process.<sup>118</sup> Moreover, by not focusing on negligence, the rate schedule supports disclosure of medical errors and improvement in the health care system.<sup>119</sup> Nevertheless, the combination of expert judges and rate schedule causes some consumer advocates to characterize the health court proposal as “not only depriv[ing] plaintiffs of the right to a trial by jury but also . . . establish[ing] caps on noneconomic damages . . . . This is totally an attempt to give HMOs, hospitals and doctors a private tribunal where there’s little justice but a lot of predictability for defendants.”<sup>120</sup> During the June 2006 Senate committee hearings, the American Bar Association (ABA) testified to the inherent unfairness of the rate schedule: “Would it be fair to award a prefixed award for negligence that resulted in a paralyzed hand for a surgeon, lost or impaired vision for an artist, or lost or impaired hearing for a musician?”<sup>121</sup>

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damages by suggesting “some kind of eligibility threshold . . . to control the number and costs of claims brought.” *Id.* The implementation of such a threshold seems reminiscent of the current system’s litigation bar, and contrary to her efforts in addressing “the undercompensation problem.”

113. Common Good, *supra* note 6.

114. Eliasberg, *supra* note 33. Recognizing the lack of consistency in jury awards, researchers submitted the same fact pattern to 120 mock six person juries and found a standard deviation of \$344,566 in the noneconomic damage awards. Shari Seidman Diamond et al., *Juror Judgments about Liability and Damages: Sources of Variability and Ways To Increase Consistency*, 48 DEPAUL L. REV. 301, 305, 314 & tbl.3 (1998).

115. Eliasberg, *supra* note 33.

116. Mello et al., *supra* note 49, at 468.

117. Eliasberg, *supra* note 33 (quoting Professor Troyen Brennan, who helped develop the Common Good model).

118. See Mello et al., *supra* note 49, at 464.

119. *Id.* at 473.

120. Romano, *supra* note 25, at 26 (quoting Jamie Court, Executive Dir., Found. for Taxpayer & Consumer Rights).

121. ABA Network, Tort Law: Health Courts, <http://www.abanet.org/poladv/priorities/>

Essentially, proponents intend for health courts to promote predictability and the compensation of victims via the implementation of four logistical elements: determination of physician negligence by expert judges, solicitation of testimony from neutral experts, restriction of attorney profits, and distribution of noneconomic damage awards through the use of the rate schedule. The risks related to the implementation of health courts, however, outweigh the limited benefit they may offer over the current litigation scheme. Given the drastic nature of the proposed changes, it is important to compare the two models before committing to a complete overhaul of medical malpractice litigation.

## *II. Comparing Health Courts to the Traditional Tort System*

In Pennsylvania—one of the AMA’s crisis states<sup>122</sup> and a likely grant candidate under the Fair and Reliable Medical Justice Act—the Project on Medical Liability independently explored litigation alternatives, including the feasibility of the implementation of special health courts, such as those proposed by Common Good.<sup>123</sup> Funded by the Pew Charitable Trusts, the Project’s mission was to serve as an independent, impartial voice on medical liability, and malpractice issues and provide decision-makers with objective information about the ways in which medical, legal, and insurance-related issues affect the medical liability system and malpractice reforms.<sup>124</sup> Ultimately, despite the model’s endorsement by the president of the Pennsylvania Medical Society,<sup>125</sup> the Project characterized the health court model as “unpromising,” and concluded that “[a]n examination of the court proposed for Pennsylvania . . . reveals serious risks of increased politicization [of the bench], narrowed judicial perspective, and greater costs to litigants.”<sup>126</sup> The Project found that Common Good’s goals could be accomplished without a complete overhaul of the traditional litigation system.<sup>127</sup> After exploring the birth and evolution of medical malpractice in the United

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healthcourts.html (last visited May 3, 2007).

122. See Am. Med. Ass’n, *supra* note 15.

123. Press Release, The Pew Charitable Trusts, Pew Trusts Invest \$3.2 Million to Research Medical Liability in Pennsylvania and Identify Possible Reforms (Mar. 15, 2002), [http://www.pewtrusts.com/ideas/ideas\\_item.cfm?content\\_item\\_id=986&content\\_type\\_id=16&issue\\_name=Medical%20liability&issue=32&page=16&name=Pew%20Press%20Releases](http://www.pewtrusts.com/ideas/ideas_item.cfm?content_item_id=986&content_type_id=16&issue_name=Medical%20liability&issue=32&page=16&name=Pew%20Press%20Releases); see also CATHERINE T. STRUVE, PROJECT ON MED. LIAB. IN PA., EXPERTISE IN MEDICAL MALPRACTICE LITIGATION: SPECIAL COURTS, SCREENING PANELS, & OTHER OPTIONS 2-3 (2003).

124. See Project on Medical Liability in Pennsylvania, <http://www.pewtrusts.org/ideas/indx.cfm?issue=32> (last visited May 3, 2007).

125. William W. Lander, *Malpractice—A Medical Crisis: It’s Time for Special Health Courts in Pennsylvania*, TRIB.-DEMOCRAT, Oct. 14, 2005, available at [http://www.tribune-democrat.com/siteSearch/apstorysection/local\\_story\\_287100437.html](http://www.tribune-democrat.com/siteSearch/apstorysection/local_story_287100437.html).

126. STRUVE, *supra* note 123, at 4-5.

127. *Id.* at 80-81. “[P]rocedural reform should focus . . . on supporting the efforts of judges and juries to assess scientific and medical questions and on providing guidance for the award and review of noneconomic damages.” *Id.* at 91.

States, this Part compares Common Good's health court model with the traditional tort system in terms of equity of judgments, transactional costs, efficiency of dispute resolution and compensation, liability insurance premiums, and the cost of health care.

### *A. The History of American Medical Malpractice Litigation*

Written in the 1760s, Blackstone's *Commentaries on the Laws of England* introduced the American colonies to the concept of medical malpractice as "[i]njuries . . . by the neglect or unskilful [sic] management of [a person's] physician, surgeon, or apothecary . . . because it breaks the trust which the party had placed in his physician, and tends to the patient's destruction."<sup>128</sup> The first actions against negligent physicians, however, did not begin to surface in the United States until the middle of the 1800s with the onset of "marketplace professionalism."<sup>129</sup> Because the states avoided regulating professions like medicine and law, herbal healers competed with European-trained surgeons for the business of health care consumers.<sup>130</sup> The lack of regulation and a uniform standard of care forced victims of malpractice to seek recourse by holding individual practitioners to whatever standard the victim or the victim's lawyer wanted to impose.<sup>131</sup> Courts aided the growth of the budding legal field by easing requirements for initiating tort claims, leading to an "explosion of medical malpractice suits" and a 950% increase in appellate review from 1840 to 1860.<sup>132</sup>

Although most physicians initially embraced the idea of weeding out their negligent peers, by 1850,

the nation's best-educated and most professionally minded physicians observed with a sort of defensive incredulity and disbelieving horror that many, if not most, of the burgeoning numbers of malpractice suits were being lodged not against charlatans and amateur hacks, but against others like themselves, the best-educated and most successful physicians.<sup>133</sup>

As patients increasingly sued the more wealthy physicians instead of the herbal healers who had fewer assets, physicians in the 1850s largely "regarded the spread of malpractice litigation as a quasi-revolutionary assault,"<sup>134</sup> with one famously stating that malpractice lawyers "follow us as the shark does the emigrant ship."<sup>135</sup>

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128. WILLIAM BLACKSTONE, 3 COMMENTARIES \*122.

129. Mohr, *supra* note 14, at 1732.

130. *Id.*

131. *Id.*

132. *Id.*

133. *Id.* at 1732-33.

134. *Id.*

135. *Id.* at 1733-34.

The advent of liability insurance at the end of the nineteenth century solved the liability problem for individual physicians and thus rendered tort actions the main vehicle for victim compensation.<sup>136</sup> Despite the medical advancements achieved over the last 150 years, medical malpractice litigation and the polarization of the medical and legal communities that began in the mid-1800s still exist today.<sup>137</sup> Only now, doctors are fleeing states with the highest liability insurance premiums, and some commentators worry that this exodus will limit the availability of care in some areas of the country.<sup>138</sup> Though most can agree that change is needed, it is crucial to ensure that the proposed alternative will in fact solve the problems associated with the traditional litigation system.

### *B. Equity of Judgments*

Proponents of Common Good's health court model seek to prevent the inequities of the current system—namely, the under-compensation of actual malpractice victims, the unfair compensation of meritless claims, and disparate damage awards across fact patterns.<sup>139</sup> A 1984 study of medical malpractice in New York hospitals estimated that about 27,179 cases of negligence occurred in the state, but only 415 (1.5%) resulted in legal action, suggesting an overwhelming number of uncompensated patients.<sup>140</sup> A 1999 Institute of Medicine report approximated that 98,000 patients may die of preventable medical mistakes annually.<sup>141</sup> Ultimately, “[t]oo few claims are asserted, in that many of those injured by medical negligence never bring a claim; yet too many claims are asserted, in that some suits turn out to lack merit.”<sup>142</sup> These statistics—coupled with the fact that defendants win about 75% to 80% of malpractice cases<sup>143</sup>—suggest that plaintiffs often file meritless claims and try to convince juries to award unfair compensation payments. The variability of noneconomic damage awards across juries further compounds the compensation problem.<sup>144</sup> Common Good's health court proposal builds on these assumptions

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136. *Id.* at 1735.

137. *Id.* at 1731-37.

138. *Scalpel, Scissors, Lawyer*, *supra* note 69, at 51 (“Pennsylvania lost a third of its general surgeons between 1995 and 2002.”).

139. See Mello et al., *supra* note 49, at 465-66.

140. Localio et al., *supra* note 56, at 248 fig.1.

141. INST. OF MED., NAT’L ACAD. OF SCIS., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM I (1999).

142. Struve, *supra* note 34, at 34. *But see* Romano, *supra* note 25, at 26 (“The percentage of [medical malpractice] cases that go to trial . . . is typically lower than most other tort claims.”) (quoting Professor Catherine Struve, Univ. of Penn. Law School).

143. See BUREAU OF JUSTICE STATISTICS, U.S. DEP’T OF JUSTICE, MEDICAL MALPRACTICE TRIALS AND VERDICTS IN LARGE COUNTIES, 2001 (2004) (reporting that “[t]he overall win rate for medical malpractice plaintiffs (27%) was about half of that found among plaintiffs in all tort trials (52%)”), available at <http://www.ojp.usdoj.gov/bjs/pub/pdf/mmtv1c01.pdf>; Eliasberg, *supra* note 33.

144. Diamond et al., *supra* note 114, at 318 & tbl.3 (noting a high variability in noneconomic

to push for adjudication by expert judges as a way to achieve equity and accuracy.<sup>145</sup>

### *1. Processing Expert Testimony: The Jury Versus Expert Judges*

Perhaps the most radical component of the health court model is the substitution of expert judges for the civil jury—the poster scapegoat for the malpractice crisis.<sup>146</sup> A staple in the traditional tort regime, the jury “by definition [is] an . . . experience in the conduct of serious human affairs that, virtually from its inception, has been the subject of deep controversy.”<sup>147</sup> Juries in medical malpractice trials must discern whether a defendant physician’s conduct was reasonable given the medical custom standard set forth by expert testimony.<sup>148</sup> “When the jury is working well, it represents a fair cross-section of the community . . . [which] seems better than relying on an elite group who all have similar training and biases that go along with that training—whether in law school or medical school.”<sup>149</sup> This ignorance, however, necessitates education on the appropriate standard of care by “hired gun” experts, which perpetuates inconsistent verdicts across juries.

By replacing lay juries with judges with medical expertise, health courts offer increased consistency in the determination of standards of care. Instead of listening to experts hired by the parties, judges would have the authority to consult neutral experts in each area of medicine,<sup>150</sup> thus eliminating adversarial testimony: “The point is not to shield bad doctors from legal consequences but to ensure that judgments are based on sound science rather than on compelling theatrics.”<sup>151</sup> Intuitively, the jury’s unfamiliarity with complex medical terminology and procedures, combined with the presentation of sympathetic fact patterns, suggests a bias that might unfairly favor a victim plaintiff.

In reality, defendants win most malpractice verdicts.<sup>152</sup> A Bureau of Justice Statistics study on medical malpractice trials and verdicts in the country’s

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damage awards in a study of 120 mock juries).

145. See Common Good, *supra* note 6.

146. See, e.g., Howard, *supra* note 73 (“Fear of erratic jury decisions in medical malpractice cases has spawned a culture of fear, causing inefficiencies that infect every level of medicine.”).

147. HARRY KALVEN, JR. & HANS ZEISEL, *THE AMERICAN JURY* 3-4 (1966).

148. Jay Alexander Gold, *Wiser Than the Laws? The Legal Accountability of the Medical Profession*, 7 AM. J.L. & MED. 145, 179 (1981).

149. Eliasberg, *supra* note 33 (quoting Professor Nancy Marder). See also Nancy S. Marder, *The Myth of the Nullifying Jury*, 93 NW. U. L. REV. 877, 932 (1999) (“At the heart of the jury system . . . is a belief that jurors will bring to the task of judging their sense of justice. . . . [T]he jury often has been described as representing the ‘conscience of the community.’”).

150. Common Good, *supra* note 6.

151. MacLennan et al., *supra* note 74, at 1689.

152. Eliasberg, *supra* note 33. But see Localio et al., *supra* note 56, at 248 tbl.3 (“Of the 280 patients who had adverse events caused by medical negligence as defined by the study protocol, eight filed malpractice claims.”).

seventy-five largest counties in 2001 found that “[t]he overall win rate for medical malpractice plaintiffs . . . was [27%, which was] about half of that found among plaintiffs in all tort trials [52%].”<sup>153</sup> Plus, courts later reduce nearly half of jury verdicts,<sup>154</sup> indicating judicial review of the more outlying awards. The media fuels the perception of plaintiff-friendly juries awarding frequent windfall payments by reporting cases with verdicts between four and thirty-four times greater than the average case.<sup>155</sup>

For example, in November 2005, the media reported that a six-member Connecticut jury awarded a record \$36.5 million<sup>156</sup> to the family of a six-year-old Nicholas Cowles, who was blind and brain-damaged and suffered from cerebral palsy (CP) due to injuries sustained during delivery by a surrogate mother.<sup>157</sup> Nicholas was present at trial, and jury foreman Julia Torres commented that “we all wanted to reach out and hug him.”<sup>158</sup> The jury found that the obstetrician failed to properly interpret data from an electronic fetal monitoring (EFM) device, which should have indicated that the fetus was in distress.<sup>159</sup> The length of the difficult delivery was so long that it caused the fetus to suffer from a dangerous increase in blood acidity, and jurors concluded that Nicholas should have been delivered via Caesarean section long before he actually was.<sup>160</sup> Torres said “[h]ad the Caesarean been performed even [thirty] minutes earlier, Nicholas would be fine today. It was just tragic that it happened that way.”<sup>161</sup>

Jurors in the Cowles trial found the appropriate standard of care to include use of the data from the monitoring strips in determining the necessity of a C-section.<sup>162</sup> As average American citizens with limited medical backgrounds, they undoubtedly reached their decision by weighing the testimony of dueling experts.<sup>163</sup> This reliance on expert testimony is a necessary component of a lay jury’s decision-making process and propagates the perception of arbitrary decisions. Health courts could potentially remedy this through judicial selection

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153. BUREAU OF JUSTICE STATISTICS, *supra* note 143.

154. Joseph T. Hallinan, *In Malpractice Trials, Juries Rarely Have the Last Word*, WALL ST. J., Nov. 30, 2004, at A1.

155. Deborah L. Rhode, *F frivolous Litigation and Civil Justice Reform: Miscasting the Problem, Recasting the Solution*, 54 DUKE L.J. 447, 463 (2004).

156. The \$36.5 million Cowles award is nearly sixteen times greater than the median award for malpractice in childbirth cases of \$2.3 million, MacLennan et al., *supra* note 74, at 1688, and eighty-six times the average malpractice award of \$320,000, CONG. BUDGET OFFICE, *supra* note 18, at 4.

157. Reitz, *supra* note 74.

158. *Id.*

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.*

163. See Gold, *supra* note 148, at 179.

of a “neutral expert,”<sup>164</sup> but it is unclear what characteristics a “neutral expert” might possess or whether neutral experts even exist in such a controversial area of medicine.

In fact, most clinicians do not believe that babies acquire CP from the failure of the obstetrician to deliver them by C-section.<sup>165</sup> Studies conducted on the efficacy of EFM patterns, like those presented in the Cowles trial, have demonstrated that the use of EFM “has not led to a decreased rate of [CP].”<sup>166</sup> Still, the fear of litigation pushes some doctors to perform unnecessary C-sections, exposing mothers to increased risks of hemorrhage, infection, and postpartum complications.<sup>167</sup> A 2006 study examined characteristics of repeat expert witnesses in 827 neurologic birth injury cases and identified 71 physicians who participated in 738 (or 89%) of the selected cases.<sup>168</sup>

If the EFM read-outs that acted as the foundation for the Cowles case are not an effective method for determining fetal distress, then these hired medical experts should cease perpetuating those beliefs. Even members of the medical community have suggested that professional schools should “train, register, and audit those offering medicolegal opinion,” such that “any expert asserting that a CP outcome was preventable . . . should have to produce evidence of good medical quality that the advocated policy has reduced rates of CP.”<sup>169</sup> Thus, if the medical community desires a uniform standard of care, it should police medical experts and their testimony to reflect accepted standards of the medical profession. Implementing measures to ensure the accountability of these experts would significantly minimize the effect of dueling experts on lay juries without depriving malpractice victims of a jury trial.

Furthermore, taking malpractice cases away from juries may be unwarranted. A 2006 study conducted at the Harvard School of Public Health challenges the common view among tort reformers that the traditional tort scheme entertains and cultivates frivolous claims.<sup>170</sup> Out of a random sample of 1452 completed malpractice claims from five insurers, 3% did not involve medical injuries and 37% did not involve medical errors;<sup>171</sup> in other words, the Harvard researchers agreed with the verdicts of a majority of lay juries. According to lead researcher Professor David Studdert, “We found the system did reasonably well in sorting the good claims from the bad ones, but there were

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164. Common Good, *supra* note 6.

165. MacLennan et al., *supra* note 74, at 1688; *Scalpel, Scissors, Lawyer*, *supra* note 67, at 52.

166. MacLennan et al., *supra* note 74, at 1689.

167. *Id.*

168. Aaron S. Kesselheim & David M. Studdert, *Characteristics of Physicians Who Frequently Act As Expert Witnesses in Neurologic Birth Injury Litigation*, 108 OBSTETRICS & GYNECOLOGY 273, 275 (2006). The judgments for the 827 cases totaled \$2.9 billion. *Id.*

169. MacLennan et al., *supra* note 74, at 1689.

170. See David M. Studdert et al., *Claims, Errors, and Compensation Payments in Medical Malpractice Litigation*, 354 NEW ENG. J. MED. 2024 (2006).

171. *Id.* at 2026, 2028 fig.1.

problems.”<sup>172</sup> Still, these problems do not seem to warrant an overhaul of the entire system, especially with the availability of modest but effective supplemental reforms.<sup>173</sup>

## 2. Preventing the Practice of Defensive Medicine and Establishing a Standard of Care

Howard has explained that, “[a] reliable system of medical justice could take many forms, but . . . the key element must be expert judges ruling on standards of care.”<sup>174</sup> The veritable lack of a uniform standard of care has led to the practice of defensive medicine—defined as “a deviation from sound medical practice that is induced primarily by a threat of liability.”<sup>175</sup> Although the phenomenon is well documented,<sup>176</sup> researchers do not agree on the amount spent on defensive medicine, and the topic remains highly controversial, because it is difficult to isolate what services are solely defensive.

A recent study supported by the Project on Medical Liability in Pennsylvania found that nine out of ten physicians in six especially high-risk specialties practice defensive medicine ranging from ordering extra tests to avoiding patients perceived to pose a litigation risk.<sup>177</sup> The Office of Technology Assessment, however, found that “a relatively small proportion of all diagnostic procedures—certainly less than 8 percent overall—is performed *primarily* due to conscious concern about malpractice liability risk.”<sup>178</sup> The Congressional Budget Office (CBO) determined “[o]n the basis of existing studies and its own research . . . that savings from reducing defensive medicine would be very small,” with no statistically significant discrepancy in health care spending per capita between states with restrictive limits on malpractice claims and states without them.<sup>179</sup> Still, the reduction of unnecessary and potentially harmful invasive procedures like biopsies is needed and may come with the development of uniform clinical standards of care.<sup>180</sup>

The written decisions by the expert judges presiding over health courts

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172. Alicia Chang, *Study Asserts Many Medical Malpractice Suits Groundless*, HOUSTON CHRON., May 11, 2006, at A11.

173. Diamond et al., *supra* note 114, at 318.

174. Philip K. Howard, Op-Ed., *The Best Course of Treatment*, N.Y. TIMES, July 21, 2003, at A15.

175. Studdert et al., *supra* note 16, at 2616.

176. See *id.*; OFFICE OF TECH. ASSESSMENT, U.S. CONG., DEFENSIVE MEDICINE AND MEDICAL MALPRACTICE (1994); P.C. Coyte et al., *Medical Malpractice: The Canadian Experience*, 324 NEW ENG. J. MED. 89 (1991); N. Summerton, *Positive and Negative Factors in Defensive Medicine: A Questionnaire Study of General Practitioners*, 310 BRITISH MED. J. 27 (1995).

177. Studdert et al., *supra* note 16, at 2616.

178. OFFICE OF TECH. ASSESSMENT, *supra* note 176, at 74 (emphasis added).

179. CONG. BUDGET OFFICE, *supra* note 18, at 6.

180. Studdert et al., *supra* note 16, at 2617.



would serve to establish uniform precedents and guidelines for patient care.<sup>181</sup> Appointed by a nonpartisan screening committee, the judges would adjudicate only health care matters.<sup>182</sup> Unlike generalist judges and lay juries, expert medical judges could rely upon their familiarity with medical custom to more accurately apply the appropriate standard of care and to achieve consistency across the state.

Some jurisdictions, however, are moving towards a “reasonable physician” standard of care instead of the traditional medical custom standard, thus minimizing the desirability of expert judges skilled at hearing the traditional standard.<sup>183</sup> Generalist judges may be better equipped to determine the reasonable care standard by drawing upon their familiarity with other tort areas. Along with specialization in a particular field of law comes de-familiarization with other legal doctrines, such that “the specialists’ field may diverge from the larger body of law and may also lose the benefit of experience in other fields.”<sup>184</sup>

Moreover, because health courts cover such a narrow and highly contentious area of law, there is an extremely high risk of politicization of the health court bench.<sup>185</sup> The ABA’s Commission on the Twenty-First Century Judiciary found that recent state judicial election campaigns have been politicized due to the participation of “interest groups that formed to promote a specific political issue.”<sup>186</sup> Given the highly polarized atmosphere of the malpractice issue, neither the appointment nor the election of medical judges could be expected to escape intense lobbying by consumer groups, trial attorneys, physicians, and insurance providers.<sup>187</sup>

In the current litigation system, the incentives to lobby for a sympathetic judge are muted by the fact that malpractice cases are distributed among a number of judges, each of whom hears only a small portion of the total claims in any given state. In other words, the threat of politicization is spread out over many judges hearing many kinds of cases. With fewer venues and fewer judges, the political pressures applied from all sides of the malpractice debate would inevitably pervade the health court bench, jeopardizing the goal of providing “a reliable system of medical justice.”<sup>188</sup>

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181. Common Good, *supra* note 6.

182. *Id.*

183. Philip G. Peters, Jr., *The Quiet Demise of Deference to Custom: Malpractice Law at the Millennium*, 57 WASH. & LEE L. REV. 163, 164 (2000).

184. STRUVE, *supra* note 123, at 75.

185. *Id.*

186. AM. BAR ASS’N, COMM’N ON THE 21ST CENTURY JUDICIARY, JUSTICE IN JEOPARDY 22 (2003).

187. See STRUVE, *supra* note 123, at 74.

188. *Id.* at 69.

*C. Per Trial and Net Transactional Costs*

Perhaps the greatest inequities of the current system are the inaccessibility of the courtroom to malpractice victims with lesser damages and the under-compensation of successful victim plaintiffs.<sup>189</sup> Both of these sources of inequity are related to the transactional costs of the traditional tort system: “Those patients with small claims often cannot find a lawyer to represent them, while those who win find their lawyers have swallowed half the payout from the doctors.”<sup>190</sup> Research has revealed that sixty cents of every dollar paid in malpractice premiums go to legal fees, court costs, and other administrative expenses, leaving only forty cents per dollar to compensate victims of medical negligence.<sup>191</sup> In 2002, the average malpractice claim payment had increased to \$320,000.<sup>192</sup> Thus, after paying off all litigation-related expenses, the average victim receives only \$128,000 to cover damages.

Common Good’s health court proposal seeks to make litigation more affordable to those injured by negligence through adjudication by an expert tribunal, education of the tribunal by neutral experts, and a 20% cap on contingency fees.<sup>193</sup> Without the expenses of assembling a jury, compensating dueling experts, or relinquishing 20% of damages to trial attorneys, the cost of litigating in health courts is estimated by Common Good to be half of what it is now.<sup>194</sup> Because health court cases would be less expensive to litigate per trial, fewer claimants would choose to settle,<sup>195</sup> and more victims with less severe injuries would gain access to the courts. Nevertheless, attorneys make the ultimate decision of whether a claim should be litigated; if their contingent fees are halved, they would theoretically need to seek claims with larger payouts or litigate more claims to maintain their profit.<sup>196</sup>

Currently, sixteen states restrict contingent fees in medical malpractice or

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189. See Mello et al., *supra* note 49, at 465-66 (“A major shortcoming of the current tort liability system is that the negligence standard leaves many patients with preventable injuries ineligible for compensation. Because only about one in four injuries related to hospital treatment can be attributed to negligence, the majority of injured patients cannot access the current compensation system.” (citations omitted)).

190. *Scalpel, Scissors, Lawyer*, *supra* note 67.

191. 151 CONG. REC. 7635 (daily ed. June 29, 2005) (statement of Sen. Enzi).

192. CONG. BUDGET OFFICE, *supra* note 18, at 3-4. The average malpractice claim payment in 1986 totaled \$95,000. *Id.*

193. Common Good, *supra* note 6.

194. *Id.*

195. *But see* STRUVE, *supra* note 123, at 77 (finding that the decreased convenience—particularly for malpractice plaintiffs—might lead to an increase in dropped and settled claims, despite the potential availability of more experienced counsel concentrated near the court locales).

196. Without the expenses associated with hiring expert witnesses, the malpractice attorney may determine that a 20% contingent fee is an attractive return for some cases. See *supra* notes 98-107 and accompanying text.

personal injury cases.<sup>197</sup> When states limit fees to less than the usual 33% for personal injury cases, attorneys have less economic incentive to screen each case carefully for the likelihood of a large payout.<sup>198</sup> Therefore, capping contingent fees leads to one of two potential outcomes: abandonment of the contingent fee for an hourly rate or a significant increase in claims filed by trial attorneys to compensate for the reduced return in contingent fees.<sup>199</sup> Either result threatens to undo the proposed benefits of health courts.

Contingency fees improve access to courts for low-income plaintiffs because lawyers are paid from the settlement or judgment and not the client's pocket.<sup>200</sup> An hourly rate prevents less wealthy litigants from bringing claims, as it requires paying attorney fees prior to and regardless of any recovery. The use of an hourly rate, instead of contingent fees, would shift the burden of under-compensation from victims with the least severe injuries to victims with the least financial resources. This hardly seems to be the right result because, arguably, the most impoverished victims need compensation from damages the most. Payment of attorneys' fees by the hour also discourages efficiency and settlement, such that a plaintiff may pay high hourly rates without ever receiving any compensation for the malpractice injury.<sup>201</sup>

On the other hand, capping contingent fees might push malpractice attorneys to relax the practice of screening malpractice claims, potentially causing an influx of claims into the court system that are currently not considered worth litigating. This enhanced access to the courtroom for malpractice victims with less severe injuries is certainly one of the health court model's major selling points; however, increased courtroom access directly translates to increased litigation. As health courts would necessarily operate in regular sessions in limited venues, a boost in the number of claims could clog the circuits. For example, a proposed model for health courts in Pennsylvania provided for six circuit level courts to replace the sixty judicial districts available to hear

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197. See ALEXANDER TABARROK & ERIC HELLAND, TWO CHEERS FOR CONTINGENT FEES 16-17 tbl.1 (2005). For a fifty-state survey of restrictions on attorneys' fees, see NAT'L CONFERENCE OF STATE LEGISLATURES, STATE MEDICAL LIABILITY LAWS TABLE (2002), *available at* <http://www.ncsl.org/programs/insur/medliability.pdf>. In 2005, twelve states considered legislation that would restrict contingent fees. Nat'l Conference of State Legislatures, State Medical Malpractice Reform: 2005 Numbers at a Glance, <http://www.ncsl.org/standcomm/sclaw/medmalataglace.htm> (last visited May 3, 2007).

198. See TABARROK & HELLAND, *supra* note 197, at 18 tbl.2. A 2005 study conducted by Professors Alexander Tabarrok and Eric Helland found that, in states with restrictions on contingent fees, 18% of cases dropped before trial without settlement, and that, in states without restrictions, only 5% of cases dropped. *Id.* The researchers concluded that the data demonstrated the connection between contingent fees and trial-lawyer screening. *Id.* at 15.

199. See *id.* at 10-11.

200. G.M. Filisko, *Fee Caps Won't Solve Liability Crisis, Study Says*, ABA J., Sept. 23, 2005.

201. See Tabarrok, *supra* note 99 (reporting that "the time to settlement in medical malpractice cases is 22% longer in states that restrict contingent fees" and that, in the year following the enactment of Florida's contingent-fee restrictions in 1985, "settlement time increased by 13%").

malpractice claims under the current system.<sup>202</sup> Health courts may mean quicker trials,<sup>203</sup> but, with a limited number of courts and a flood of claims, it is unclear how the courts would handle such an overwhelming caseload.

While the cost of each health court trial might be markedly less, the total cost of compensating more litigated claims could drive up the net transactional cost of the health court system, perhaps surpassing the estimated \$6.5 billion spent on defending malpractice claims (including plaintiff awards, legal costs, and underwriting costs) in 2001.<sup>204</sup> Thus, although it would theoretically provide increased accessibility to the courtroom, the health court model would also impose increased stress on the system, perhaps diluting the benefits of lowering the litigation bar. Even Professor Troyen A. Brennan, a member of the Common Good project, concedes that “[a]n increase in the number of medical errors reported, and compensated, could drive overall malpractice costs up as much as fourfold.”<sup>205</sup> In other words, decreasing the cost per malpractice trial makes litigation an attractive option for more plaintiffs, leading to more trials, more compensation, and a higher net transactional cost.<sup>206</sup>

In contrast, there is some certainty in the current litigation system. Despite the obvious injustice of a \$200,000 bar to litigation,<sup>207</sup> the prelitigation screening of malpractice claims by trial attorneys has kept the number of malpractice claims filed each year remarkably stable.<sup>208</sup> Statistics released from the National Center for State Courts disclosed that malpractice claims per 100,000 people actually decreased by 1% from 1992 to 2001.<sup>209</sup> In general, the total number of federal and state lawsuits filed each year climaxed in the mid-1980s and has drastically decreased ever since.<sup>210</sup> Thus, practically speaking, it seems more productive to focus on the reform of a stable system with a constant number of lawsuits, than to implement a new scheme with uncertain and potentially devastating consequences.

#### *D. Efficiency in Dispute Resolution and Compensation*

Closely tied to increasing access to the courtroom is the efficiency in dispute resolution and compensation. Data collected by the National Practitioner Data Bank showed that the national average time from injury to payout in malpractice cases in 2004 was 4.61 years—one week longer than the 2003 average.<sup>211</sup> This

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202. STRUVE, *supra* note 123, at 77.

203. Common Good, *supra* note 6.

204. Anderson et al., *supra* note 1, at 910.

205. Eliasberg, *supra* note 33.

206. *See infra* Section III.B.

207. *See Romano, supra* note 25, at 26.

208. CONG. BUDGET OFFICE, *supra* note 18, at 4.

209. Romano, *supra* note 25, at 26.

210. Rhode, *supra* note 155, at 456-57.

211. NAT'L PRACTITIONER DATA BANK, U.S. DEP'T OF HEALTH & HUMAN SERVS., 2004 ANNUAL

“payment delay” ranged from 2.81 years in South Dakota to 6.69 years in Rhode Island. Unlike the current tort system, Common Good’s health court model separates the determinations of liability (and economic damages) and compensation for noneconomic damages: expert judges establish whether malpractice occurred and the amount of economic losses, while a predetermined rate schedule sets noneconomic damages for various injuries.<sup>212</sup> Without the need to educate a jury, Common Good claims that its procedure will significantly increase efficiency in terms of dispute resolution and compensation such that “[m]ost cases would be resolved within months.”<sup>213</sup> Though it seems that each health court trial will take less time from injury to compensation, the net effect of increased litigation could be a clogged docket, causing even longer payment delays than those found in the current system.

In 2004, Pennsylvania’s average payment delay was 5.58 years<sup>214</sup>—nearly a year longer than the national average.<sup>215</sup> The health court model proposed there would have three-judge panels sitting in six venues across the state.<sup>216</sup> Because health courts would have original jurisdiction for all medical malpractice claims, these six courts would hear all of Pennsylvania’s malpractice claims, which are now dispersed through sixty judicial districts.<sup>217</sup> Siphoning out malpractice claims would likely make the judicial system as a whole more efficient, but with an influx of more litigation due to the decreased cost per trial, the health court docket could quickly become overwhelmed.<sup>218</sup> Moreover, “courts need not be specialized in order to implement strategies to reduce delay, such as active case management and the imposition of deadlines on discovery and dispositive motions.”<sup>219</sup>

### *E. Liability Insurance Premiums*

One of the driving forces behind the search for litigation alternatives is the ever-rising cost of liability insurance for physicians, especially in high-risk specialties like obstetrics-gynecology, surgery, anesthesiology, emergency medicine, and radiology.<sup>220</sup> In 2004, Rick Miller, a neurosurgeon in New Hampshire, refused to treat the president of the New Hampshire Trial Lawyers

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REPORT 31, 72 tbl.13 (2004), available at [http://www.npdb-hipdb.hrsa.gov/pubs/stats/2004\\_NPDB\\_Annual\\_Report.pdf](http://www.npdb-hipdb.hrsa.gov/pubs/stats/2004_NPDB_Annual_Report.pdf).

212. See Common Good, *supra* note 6; Mello et al., *supra* note 49, at 467-68.

213. Common Good, *supra* note 6.

214. NAT’L PRACTITIONER DATA BANK, *supra* note 211, at 72 tbl.13.

215. *Id.* at 31.

216. STRUVE, *supra* note 123, at 71.

217. *Id.*

218. See *supra* Section II.C.

219. STRUVE, *supra* note 123, at 72.

220. Daniel P. Kessler et al., *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 JAMA 2618, 2619 (2005).

## HEALTH COURTS

Association because of the latter's lobbying efforts against limits on malpractice suits.<sup>221</sup> Considered the best neurosurgeon on the Sea Coast, Miller paid \$84,151 a year for liability insurance, leaving him with only \$64,000 after business costs and taxes.<sup>222</sup>

That's less than my malpractice premium. This puts in perspective how desperate the situation is. Attorneys who choose to speak out and try to derail efforts at meaningful tort reform do so at some risk—that they will not be able to come to the best neurosurgeon in New Hampshire. They'll have to go elsewhere, the same way that patients will have to go elsewhere if neurosurgery is no longer available on the Sea Coast.<sup>223</sup>

Though most doctors have not bought into the refuse-to-treat tactic, they undoubtedly share Miller's concern for their own survival and for the availability of health care; after all, "[i]f physicians in [high-risk] specialties find coverage unaffordable and limit or abandon their practices, the entire health care system potentially fails."<sup>224</sup>

In marketing health courts to the medical community, Common Good implies that its model can counter "[s]tunning increases in medical malpractice premiums," thus encouraging the practice of medicine and enhancing availability of health care.<sup>225</sup> Apparently, the organization's claim that insurers will lower malpractice premiums relies on the normalization and subsequent predictability of damages.<sup>226</sup> By implementing a rate schedule to determine damages specific to a victim's injuries and abolishing the use of lay juries, health courts effectively rule out the possibility of capricious awards for noneconomic damages, which Common Good claims collectively drive up malpractice premiums.<sup>227</sup> Whether the model can live up to its proposed goal of protecting physicians from the cost of growing premiums remains uncertain.

Although malpractice litigation is frequently blamed for the current malpractice crisis, researchers have observed that there is no clear-cut correlation between trends in lawsuits and awards and trends in premiums or insurance availability.<sup>228</sup> Insurance providers rely on the influx of premium payments and investment capital to fund claim payments and other administrative costs.<sup>229</sup>

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221. Parker, *supra* note 9.

222. *Id.*

223. *Id.*

224. Sage, *supra* note 11, at 473.

225. Common Good, *supra* note 6.

226. See Mello et al., *supra* note 49, at 470 ("[A] health court system presents greater possibility for cost control than the tort system does. . . . Whether malpractice litigation costs currently exceed the socially optimal level is controversial, but the desirability of being able to control the system's costs should not be.") (citation omitted).

227. See Common Good, *supra* note 6.

228. Sage, *supra* note 11, at 470.

229. *Id.*

Premiums for malpractice insurance are set so that, over time, insurers' income from those premiums equals their total costs—including a competitive return to their investors—less any excess funds in reserve.<sup>230</sup> This insurance underwriting reflects everything from the potential risks of medical advances to the public perception of medical error.<sup>231</sup>

Malpractice premiums are a poor reflection of current litigation trends, “[b]ecause liability insurers hold premium dollars for many years before paying them out to claimants [and] the long tail also makes current pricing depend to a greater extent on investment income than is typical of other forms of insurance.”<sup>232</sup> With the average malpractice claim taking nearly five years to resolve<sup>233</sup> and some injuries being inherently latent, insurance companies must project years, and sometimes decades, into the future.<sup>234</sup> Data regarding formulas for underwriting insurance premiums has not been collected reliably on a national level, making research and studies on the topic particularly difficult.<sup>235</sup>

The first medical malpractice crisis surfaced in 1975, when many commercial insurance providers ceased or threatened to stop giving liability coverage.<sup>236</sup> During the next crisis in the mid-1980s, malpractice premiums increased significantly for a couple of years in response to a speculated increase in claims by insurance companies.<sup>237</sup> Ultimately, their speculations were too high, and insurers placed the surplus funds into reserves, which subsequently lightened the premiums for the 1990s.<sup>238</sup> From 2000 to 2002, the average malpractice premium for American physicians increased by 15%, with a 22% increase for obstetricians-gynecologists and a 33% increase for internists and general surgeons.<sup>239</sup> Given the cyclical nature of the insurance crises, it seems that malpractice crises are the result of insurance underwriting—not of periods of increased litigiousness or payouts<sup>240</sup>—and it is unclear how underwriters would respond to the uncertainties of the health court model.<sup>241</sup>

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230. CONG. BUDGET OFFICE, *supra* note 18, at 3.

231. *See* Sage, *supra* note 11, at 480.

232. *Id.*

233. NAT'L PRACTITIONER DATA BANK, *supra* note 211, at 31.

234. Sage, *supra* note 11, at 480-81.

235. U.S. GEN. ACCOUNTING OFFICE, MEDICAL MALPRACTICE: IMPLICATIONS OF RISING PREMIUMS ON ACCESS TO HEALTH CARE 40-41 (2003), available at <http://www.gao.gov/new.items/d03836.pdf>.

236. Sage, *supra* note 11, at 469.

237. *See id.* at 469-70; CONG. BUDGET OFFICE, *supra* note 18, at 4-5.

238. CONG. BUDGET OFFICE, *supra* note 18, at 4-5.

239. *Id.*

240. Sage, *supra* note 11, at 471.

241. Research suggests that even a systemic change accompanied by a sustained decrease in payouts might not deflate premiums. One study examined Texas medical malpractice claims from 1988 to 2002 and concluded that “[n]o sudden rise in claim frequency, payments, defense costs, or jury verdicts preceded or accompanied the premium spike that occurred in Texas after 1998.” Black et al., *supra* note 21, at 255.

*F. Cost of Health Care*

Despite what Common Good has suggested,<sup>242</sup> reducing malpractice premiums does not appear to have a significant effect on economic efficiency or the affordability of health care for patients. In fact, research suggests that it is the cost of treatment, not malpractice litigation, which accounts for the high cost of health care in the United States.<sup>243</sup> The CBO recently found that even a 25% to 30% savings in premiums can have only a small direct impact on health care spending, because the cost of malpractice litigation accounts for less than 2% of total health care spending in America,<sup>244</sup> regardless of the type of reform used to achieve the premium reduction.

A recent Harris poll<sup>245</sup> found that 62% of American adults supported the adjudication of medical malpractice cases in health courts.<sup>246</sup> Implying a correlation between large jury payouts and the price consumers pay to see their doctors, Common Good appeals to the public by highlighting the rising cost of health care and by offering the rate schedule for damages as an alternative to the “random justice” of jury awards.<sup>247</sup> Compensation based on the schedule would award “so much for an arm . . . rather than by having jurors pluck a number out of the air.”<sup>248</sup> The schedule would normalize damage awards across fact patterns and effectively act as a set of noneconomic damage caps itemized by injury.<sup>249</sup>

Many states that initially adopted noneconomic damage caps have since repealed them on constitutional grounds, including Alabama, Illinois, Kentucky, New Hampshire, North Dakota, Oregon, and Washington.<sup>250</sup> Wisconsin recently

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242. Common Good, *supra* note 6.

243. Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 23 HEALTH AFF. 89 (2003).

244. CONG. BUDGET OFFICE, *supra* note 18, at 6.

245. Harris Interactive is one of the largest market research firms in the country and also manages the longest running independent opinion poll. Harris Interactive, About Us, <http://www.harrisinteractive.com/about/> (last visited May 3, 2007).

246. Common Good, Senate Majority Leader Bill Frist Calls for the Creation of Special Health Courts (July 19, 2004), <http://cgood.org/healthcare-newscommentary-inthenews-140.html>.

247. Common Good, *supra* note 6.

248. *Scalpel, Scissors, Lawyer*, *supra* note 67.

249. See Eliasberg, *supra* note 33.

250. See ALA. CODE § 6-5-544 (2003), *invalidated by* Mobile Infirmary Med. Ctr. v. Hodgen, 884 So. 2d 801, 813-14 (Ala. 2003) (holding that the cap on noneconomic damages in medical malpractice cases violated the right to jury trial and the equal protection provisions of the Alabama Constitution); 735 ILL. COMP. STAT. 5/2-1115.1 (1996), *invalidated by* Best v. Taylor Mach. Works, 689 N.E.2d 1057, 1066-81 (Ill. 1997) (holding that the limitation on compensatory damages for noneconomic injury violated the Illinois Constitution); KY. REV. STAT. ANN. § 304.40-270 (West 1980), *invalidated by* McCoy v. W. Baptist Hosp., 628 S.W.2d 634, 635 (Ky. Ct. App. 1981) (finding the statutory cap unconstitutional as an invasion of the rule-making power of the courts); N.H. REV. STAT. ANN. § 507-C:7 (1980), *invalidated by* Carson v. Maurer, 424 A.2d 825, 830-31 (N.H. 1980) (holding that the cap on noneconomic damages in medical malpractice actions violated the equal protection clause of the New Hampshire Constitution); N.D. CENT. CODE § 26-40.1-11



implemented a second, significantly higher damage cap to replace the one struck down in *Ferdon ex rel. Petrucelli v. Wisconsin Patients Compensation Fund*.<sup>251</sup> In that case, the Supreme Court of Wisconsin found statistics in Wisconsin mirroring those in the CBO's report and held the state's \$350,000 noneconomic damage cap to be unconstitutional because

even if the \$350,000 cap on non-economic damages would reduce medical malpractice insurance premiums, this reduction would have no effect on a consumer's health care costs. Accordingly, there is no objectively reasonable basis to conclude that the \$350,000 justifies placing such a harsh burden on the most severely injured medical malpractice victims.<sup>252</sup>

Between the *Ferdon* decision and the passage of the new cap, the Wisconsin Hospitals Association reported that Wisconsin hospitals had difficulty recruiting physicians and that the number of malpractice claims increased.<sup>253</sup> PIC Wisconsin, the largest provider of liability insurance in the state, raised premiums by 5% in January 2006, tentatively waiting for lawmakers and the state supreme court to chart a new course.<sup>254</sup>

Prior to signing the new \$750,000 damage cap for malpractice cases,<sup>255</sup> Governor Jim Doyle vetoed an attempt by the Wisconsin Legislature to pass a \$450,000 cap because the proposal "suffer[ed] from the exact same constitutional defects" as the unconstitutional cap in *Ferdon*.<sup>256</sup> The governor reportedly felt that "[a]pproving a law that would be quickly overturned doesn't do anyone any good."<sup>257</sup> The *Ferdon* court found that the \$350,000 noneconomic damage cap "was designed by the legislature to help limit the increasing cost of health care

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(1977), *invalidated by* Arneson v. Olson, 270 N.W.2d 125, 131-36 (N.D. 1978) (holding that the \$300,000 cap on medical malpractice awards was a violation of equal protection); OR. REV. STAT. § 18.650(1) (1999), *invalidated by* Lakin v. Senco Prods., Inc., 987 P.2d 463, 465-69 (Or. 1999) (holding that the noneconomic damage cap unconstitutional for abridging the right to jury trial); WASH. REV. CODE ANN. § 4.56.250 (1988), *invalidated by* Sofie v. Fibreboard Corp., 771 P.2d 711 (Wash. 1989) (holding that the noneconomic damage cap violated the Washington Constitution and the right to a jury trial).

251. Wis. Office of the Governor, *supra* note 7; *see also* WIS. STAT. § 893.55 (2005), *invalidated by* *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440 (Wis. 2005) (holding that the statutory cap failed to demonstrate a rational relationship to legislative objectives).

252. 701 N.W.2d at 485. *See also* CONG. BUDGET OFFICE, *supra* note 18, at 6. The \$350,000 cap mentioned in *Ferdon* was indexed for inflation and reached \$445,775 when the Wisconsin Supreme Court struck it down in July 2005. David Wahlberg, *Medical Malpractice Caps Have Little Effect on Rates*, WIS. ST. J., Mar. 5, 2006.

253. Stacy Forster & Derrick Nunnally, *Doyle Vetoes Medical Malpractice Caps: Limits Too Similar to Those Overturned by Court, Governor Says*, MILWAUKEE J. SENTINEL, Dec. 2, 2005, available at <http://www.jsonline.com/news/state/dec05/375058.asp>.

254. *Id.*

255. Wis. Office of the Governor, *supra* note 7.

256. Forster & Nunnally, *supra* note 253.

257. *Id.*

## HEALTH COURTS

and possible ‘diminishing . . . availability of health care in Wisconsin.’”<sup>258</sup> Ultimately, the court struck down the cap as unconstitutional because the legislature failed to demonstrate a rational relationship to the legislative objectives, finding that “the correlation between caps on noneconomic damages and the reduction of medical malpractice premiums or overall health care costs is at best indirect, weak, and remote.”<sup>259</sup> Sixty-eight percent higher than the unconstitutional cap in *Ferdon*,<sup>260</sup> Wisconsin’s legislature hopes that its new \$750,000 cap will not suffer the same fate as its predecessor and will return stability to the state’s malpractice environment.

Drawing from the concept of noneconomic damage caps, Common Good’s plan attempts to circumvent the inequity of capping all claims at the same amount by creating a rate schedule for injury-specific noneconomic damages.<sup>261</sup> Damages awarded by health courts would include economic damages (such as lost wages and hospital bills) and noneconomic damages according to the schedule.<sup>262</sup> Common Good equates this prevention of “random justice” with the ability to provide affordable health care to consumers, but given the lesson learned in *Ferdon*, it seems unlikely that providing varied injury-specific damage caps would strengthen the link between restricting damage awards and lowering the cost of health care.

In sum, health courts may lower the litigation bar to encourage victim compensation and cultivate a uniform standard of care to guide physicians. Unfortunately, they would also increase the new transactional cost of malpractice litigation, postpone victim compensation, and raise liability insurance premiums without providing significantly more equitable results<sup>263</sup> or lowering health care costs. These shortcomings of the health court model can be suggested from a piecemeal assessment of nontraditional litigation alternatives in California, Wisconsin, and New Jersey.

## III. CASE STUDIES

Outside of the unpopular refuse-to-treat tactic, the health court model is one of the most radical approaches in battling the malpractice crisis. A drastic

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258. *Ferdon ex rel. Petrucelli v. Wis. Patients Comp. Fund*, 701 N.W.2d 440, 465 (Wis. 2005).

259. *Id.* at 485.

260. Press Release, Wis. Hosp. Ass’n, Hospitals Praise Bipartisan Vote on Damage Caps: Senate Sends Bill to Gov. Doyle with Another Strong Vote (Mar. 8, 2006), <http://www.wha.org/newsCenter/pdf/nr3-8-06senateab1073.pdf>.

261. Eliasberg, *supra* note 33.

262. Common Good, *supra* note 6.

263. See, e.g., Mello et al., *supra* note 49, at 467 (conceding the realistic necessity of “cost control”); *infra* Section III.C (discussing possible inequitable consequences of the health court model). Mello suggests “some kind of eligibility threshold—a minimum . . . of [four weeks] of disability [and] a minimum amount of [\$3,000 to \$4,000 in] out-of-pocket expenses— . . . in order to control the number and costs of claims brought.” Mello et al., *supra* note 49, at 467.

departure from the current tort litigation scheme, health courts would funnel all malpractice cases to limited venues in the state judiciary for adjudication by a panel of expert judges.<sup>264</sup> As with any innovative and radical tort reform, however, integration of specialized health courts into the American judiciary system carries risks similar to other litigation alternatives: arbitration employs a pool of subject-sophisticated arbitrators to award compensation in the absence of direct consent;<sup>265</sup> medical mediation panels demonstrate the potential influx of claims into the health court system without the deterrent effect of costly litigation;<sup>266</sup> and mass tort courts are another form of specialized court experiencing an overburdened docket.<sup>267</sup> Based on this piecemeal assessment, the implementation of health courts may result in unfair compensation due to politicization of the bench and the normalization of noneconomic injuries in the rate schedule, significantly increased net transactional costs and malpractice premiums, and delayed dispute resolution and compensation.

*A. The Equity of Health Courts and California's Medical Injury Compensation Reform Act's Arbitration Provision*<sup>268</sup>

In enacting the Medical Injury Compensation Reform Act (MICRA), the California legislature acknowledged the onset of America's first medical malpractice crisis in the 1970s,<sup>269</sup> and "a potential breakdown of the health delivery system, severe hardships for the medically indigent, a denial of access for the economically marginal, and depletion of physicians such as to substantially worsen the quality of health care available to citizens of [California]."<sup>270</sup> Designed to improve the quality of health care in California, the Act includes an arbitration provision, allowing patients and their health care providers to agree that any future dispute will be adjudicated through binding arbitration.<sup>271</sup>

Although the AMA supports voluntary arbitration as a method to weed out meritless claims from litigation,<sup>272</sup> the American Arbitration Association reported that only about 60 out of the 219,000 cases it handled in one year were

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264. Mello et al., *supra* note 49, at 467.

265. *See infra* Section III.A.

266. *See infra* Section III.B.

267. *See infra* Section III.C.

268. CAL. CIV. PROC. CODE § 1295 (West 2005).

269. Sage, *supra* note 11, at 469.

270. CAL. BUS. & PROF. CODE § 6146 note (West 2003).

271. CAL. CIV. PROC. CODE § 1295. Although the Federal Arbitration Act is the primary authority on arbitration clauses in contracts governed by state law, states still have control over the substantive content of the clauses. *See* David M. Studdert & Troyen A. Brennan, *Toward a Workable Model of "No-Fault" Compensation for Medical Injury in the United States*, 27 AM. J.L. & MED. 225, 236 (2001).

272. Romano, *supra* note 25, at 29.

medical malpractice claims, which is equivalent to 0.03% of its caseload.<sup>273</sup> Given arbitration's reputation for doling out smaller awards, it is not surprising that most medical malpractice arbitrations are triggered by adhesion contracts rather than the will of the plaintiff.<sup>274</sup>

For about thirty years, one of the largest HMOs in America, Kaiser Permanente, has taken advantage of MICRA's arbitration provision by "operat[ing] a mandatory, binding arbitration scheme to judge compensation for medical injury claims arising in its facilities."<sup>275</sup> Even though Kaiser's contracts waiving the right to litigation are repeatedly challenged for the absence of informed consent,<sup>276</sup> the California Supreme Court has continually broadened the applicability of Kaiser's arbitration clause, reinforcing the state's confidence in MICRA and arbitration in medical malpractice cases: "MICRA legislation was based on an assumption that there were advantages to arbitration that would more than offset the potential lack of direct informed consent, including expedited resolution of claims, reduced costs, sophisticated decision making, and removal of disputes from the adversarial atmosphere of the courtroom."<sup>277</sup>

In fact, health courts would essentially be a mandatory and more regulated version of arbitration with far fewer arbitrators; in other words, they would have the drawbacks of MICRA without the benefits. Unlike Kaiser's contracts and the workers' compensation model (in which the "trade-off of loss of a right to bring an action in court that is counterbalanced by a 'guaranteed' award that is not fault based"),<sup>278</sup> health courts absolutely deprive would-be litigants from their right to pursue trial in the traditional system. Furthermore, without a large pool of potential judges, the health court model presents a concentrated problem of politicization, as both sides would lobby for the appointment or election of their favored judges. Moreover, the additional implementation of a rate schedule for injury-specific noneconomic damages would further limit the judges' ability to award appropriate damages.<sup>279</sup> Because health courts will not reduce the net

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273. *Id.* The American Arbitration Association states that it "provides services to individuals and organizations who wish to resolve conflicts out of court." Am. Arbitration Ass'n, About Us, <http://www.adr.org/About> (last visited May 3, 2007).

274. David Zukher, Comment, *The Role of Arbitration in Resolving Medical Malpractice Disputes: Will a Well-Drafted Arbitration Agreement Help the Medicine Go Down?*, 49 SYRACUSE L. REV. 135, 141 (1998).

275. Studdert & Brennan, *supra* note 271, at 236.

276. See *Engalla v. Permanente Med. Group*, 938 P.2d 903 (Cal. 1997) (remanding for consideration of the lower court to consider whether an arbitration agreement should be unenforceable because evidence supported fraud and bad-faith delay on the part of Kaiser); *Madden v. Kaiser Found. Hosps.*, 552 P.2d 1178 (Cal. 1976) (holding that Kaiser's medical services contract was not adhesive); *Tunkl v. Regents of Univ. of Cal.*, 383 P.2d 441 (Cal. 1963) (holding that Kaiser's contract was unenforceable because the patient was not in a position to reject the agreement).

277. Studdert & Brennan, *supra* note 271, at 237-38.

278. ABA Network, *supra* note 121.

279. Common Good, *supra* note 6.

transactional cost or expedite the resolution of claims, the health court model fails to satisfy all of the California Supreme Court's justifications for upholding Kaiser's arbitration clause under MICRA. Without certain improvement of the malpractice problem, the idea of subjecting one state's residents to mandatory adjudication similar to arbitration without consent does not appear to be equitable.

*B. The Net Transactional Cost of Health Courts and Wisconsin's Medical Mediation Panels*<sup>280</sup>

Created in 1986 by the state legislature, Wisconsin's medical mediation panels provide "an informal, inexpensive and expedient means for resolving [medical malpractice] disputes without litigation."<sup>281</sup> Claimants cannot commence court action prior to filing a request for mediation unless proceedings began within fifteen days before the filing and there have not been any discovery or pretrial or trial conferences.<sup>282</sup> The mediation panel consists of three individuals (a layperson serving a two year term, a licensed Wisconsin attorney, and a health care provider), each of whom receives \$150 in compensation per day of mediation.<sup>283</sup>

As mediations are less formal proceedings, there are no records, physical examinations, subpoenas, oaths, or expert witnesses;<sup>284</sup> however, the statutes expressly permit the mediation panel to consult and reimburse any expert it feels necessary.<sup>285</sup> The panel's decision is not binding.<sup>286</sup> Annual fees charged to health care providers and to hospitals for each occupied bed fund the costs of the mediation panel.<sup>287</sup> The availability of mediation panels potentially reduces litigation costs because the panel informally assesses the strength of the plaintiff's claim and the physician's defense, which can lead to settlements or dropped claims.

Based on available statistics from 1986 to 1994, it appears that adjudication by the mediation panels keeps a significant number of cases from entering the court system.<sup>288</sup> When cases entered mediation prior to the filing of a court claim, nearly half either settled as a direct result of mediation or became inactive after the statute of limitations had expired.<sup>289</sup> Like health courts, mediation

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280. WIS. STAT. § 655.42(1) (2005).

281. Act of June 12, 1986, No. 340, § 69m, 85 WIS. ACT 1508 (1986).

282. WIS. STAT. § 655.44, .445.

283. *Id.* § 655.465.

284. *Id.* § 655.58.

285. *Id.* § 655.58(3)(b).

286. Wis. Court Sys., Medical Mediation Panels, <http://www.wicourts.gov/about/organization/offices/mmp.htm> (last visited May 3, 2007).

287. WIS. STAT. § 655.61.

288. *See id.*

289. *Id.*

panels serve as a more affordable litigation alternative, thus inviting claims of lesser damages.<sup>290</sup> In fact, pro se litigants brought nearly 15% of the claims presented to mediation panels.<sup>291</sup> Because the financial accessibility of the mediation panels mirrors the broader courtroom access proposed by health courts, studying the distribution of cases heard by mediation panels may help demonstrate the potential increase of lesser claims under the health court model.

In mediation cases seeking damages less than \$25,000, nearly half resulted in no action after mediation and about a quarter settled at or shortly after the mediation session.<sup>292</sup> Certainly, there are many variables in deciding to pursue litigation, but it is likely that claimants dropped or settled those claims due to questionable merit or the expected cost of trying the claim in court. Victims with lesser claims may not be able to recover through mediation because a mediator's determination is not binding, thus a plaintiff's damages still have to exceed litigation costs before any compensation occurs.

Currently, the limited accessibility of litigation maintains a steady rate of about fifteen court claims filed per one hundred doctors, with 30% of those claims resulting in an insurance payment.<sup>293</sup> If health courts replaced the current litigation system, it is possible that a large portion of the 73% of the mediation panel's cases under \$25,000 that were not litigated would have been, as fewer claimants would have settled out of court if binding litigation were more feasible.<sup>294</sup> Furthermore, although the statistics are unclear as to how many cases lacked merit, at least some of the cases would have been adjudicated in health court because of the smaller perceived hurdle to potential compensation. With 90% of asserted claims dropped, dismissed, or settled before reaching trial,<sup>295</sup> the effect of lowering the litigation bar could better compensate victims with less severe injuries; but the increase in litigated claims could also overwhelm the health court docket, raise net transactional costs, and cause insurance companies to hike up malpractice premiums.

### *C. The Efficiency of Health Courts and New Jersey's Special Mass Tort Courts*<sup>296</sup>

As home to many of the world's pharmaceutical companies, New Jersey has opted to channel mass torts into specialized courts to ease the stress on the

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290. *See id.*

291. *Id.*

292. *Id.* Twenty-four percent of the cases seeking less than \$25,000 settled at or shortly after the session "[a]s a direct result of mediation." *Id.* In 49% of the cases, however, there was neither a settlement nor a filing in circuit court by the time the statute of limitations had expired. *Id.*

293. CONG. BUDGET OFFICE, *supra* note 18, at 4.

294. Wis. Court Sys., *supra* note 286.

295. Romano, *supra* note 25, at 29.

296. *See generally* Editorial, *Health Courts Are Worth a Try*, STAR-LEDGER (Newark, N.J.), July 18, 2005; Press Release, N.J. Judiciary, Adoption of Rule 4:38A – "Centralized Management of Mass Torts" (Oct. 23, 2003), <http://www.judiciary.state.nj.us/notices/n031028a.htm>.

superior courts.<sup>297</sup> Conceptually, the ability to centralize numerous substantively similar claims makes the system significantly more efficient and the results more consistent. In 2003, the New Jersey legislature established specialized courts to handle certain types of mass tort cases, including those concerning Vioxx.<sup>298</sup> Any judge or attorney involved with a potential mass tort case may apply to the New Jersey Supreme Court for designation of the case as a mass tort.<sup>299</sup> If the state's supreme court determines a case to be a mass tort, the Chief Justice will assign it to one of four superior court judges designated to exclusively manage mass tort cases under the civil section of the New Jersey Superior Court in three locations across the state.<sup>300</sup> All orders handed down in mass tort courts will be "published in the legal newspapers, and will be posted in the Mass Tort Information Center on the Judiciary's Internet website."<sup>301</sup>

Like New Jersey's mass tort courts, the proposed health courts would filter malpractice cases out of the traditional state circuits for adjudication by judges exclusively hearing health care matters.<sup>302</sup> Theoretically, the advantage of these specialized courts is two-fold: promoting efficiency in the circuits and uniformity of outcomes. Since New Jersey declared Vioxx-related injuries to be a mass tort in June 2003,<sup>303</sup> thousands of claims have been filed in New Jersey against pharmaceutical giant Merck, which is headquartered in the state.<sup>304</sup> Merck pulled Vioxx from the shelves on September 30, 2004 following FDA reports that the use of the drug may have resulted in 27,000 heart attacks and sudden cardiac deaths.<sup>305</sup> After the recall, the number of claims filed in New Jersey state courts

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297. See N.J. Judiciary, *supra* note 296.

298. N.J. R. SUPER. CT., TAX CT., & SURR. CT. CIV. R. 4:38A (2005) (authorizing the New Jersey Supreme Court to designate a case or category of cases as a mass tort for centralized adjudication). Other New Jersey mass torts currently include Accutane, asbestos, Bextra/Celebrex, Ciba Geigy, diet drugs, hormone-replacement therapy (HRT), Long Branch Manufactured Gas Plant (LBMGP), lead paint, phenylpropionolamine (PPA), and tobacco. *Id.*; see also Richard J. Williams, Admin. Dir. of the Courts, Directive 11-03, Mass Torts—Guidelines and Criteria for Designation (Oct. 27, 2003), available at [http://www.judiciary.state.nj.us/directive/civil/dir\\_11\\_03.pdf](http://www.judiciary.state.nj.us/directive/civil/dir_11_03.pdf) (setting forth the mass-tort guidelines).

299. Williams, *supra* note 298. New Jersey Directive 11-03 lists fourteen non-exclusive factors considered in determining whether a case should be designated as a mass tort and provides "a procedure for interested attorneys to have input into the process." *Id.*

300. N.J. Judiciary, Mass Tort Frequently Asked Questions, <http://www.judiciary.state.nj.us/mass-tort/faq.htm> (last visited May 3, 2007). Subsequent cases that fall within the established mass tort categories transfer automatically to the appropriate mass tort judge. Williams, *supra* note 304.

301. Williams, *supra* note 298.

302. STRUVE, *supra* note 123, at 71.

303. N.J. Judiciary, Notice to the Bar, RE: Designation of Vioxx Litigation as a Mass Tort (June 6, 2007), available at <http://www.judiciary.state.nj.us/notices/n030611a.htm>.

304. John Curran, *Vioxx Cases Would Take Judge 583 Years To Hear*, TALLAHASSEE DEMOCRAT, Dec. 26, 2005, at A7.

305. John Covalleski, *Mass Tort Docket Grows in New Jersey as HRT, Vioxx Litigation Multiplies*, N.J. L.J., Oct. 15, 2004, available at <http://www.law.com/jsp/article.jsp?id=1097686249066>.

ballooned from 175 to 4333.<sup>306</sup> The state supreme court centralized all of the New Jersey Vioxx cases and assigned them to superior court Judge Carol Higbee—a former malpractice attorney chosen for her familiarity with mass torts and “largely because other vicinages handling mass torts have full caseloads.”<sup>307</sup> In the end, if the 4333 Vioxx cases in New Jersey had not been centralized, they would have clogged the dockets of the various superior courts, which in turn could compound inefficiency with inconsistent holdings.

The efficiency of the judicial system as a whole, however, does not necessarily include the efficiency of the specialized court. “If [New Jersey’s 4,333 Vioxx cases] all go to trial and take as long as a recent, seven-week case, Higbee would need 583 years to hear them all.”<sup>308</sup> At that rate, while the liability portion of the trials might be efficient, the damage calculation for individual victims could take years following the filing of a claim. Furthermore, a mass tort in New Jersey is defined by an identification of certain common case characteristics,<sup>309</sup> whereas medical malpractice claims are inherently fact-intensive. Thorough adjudication of these facts would only add to the length of trials and the amount of time victims of medical negligence would have to wait to receive compensation. Common Good has asserted that “[p]atients injured by mistakes should be compensated for their injuries without waiting years,”<sup>310</sup> but even assuming that the use of health courts would reduce the actual length of each trial, specialized courts do not guarantee more timely compensation.<sup>311</sup>

## CONCLUSION

Ultimately, Common Good’s health court model falls short of its advocates’ expectations, and its potential benefits do not sufficiently outweigh its likely costs for the United States to abandon using the traditional tort system for medical malpractice claims. Admittedly, there are problems with the current litigation scheme. Unlike the uncertainty that would come with implementing health courts, however, the problems with malpractice litigation are predictable

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306. *Id.*; Curran, *supra* note 304.

307. Covalenski, *supra* note 305.

308. Curran, *supra* note 304.

309. N.J. JUDICIARY, NEW JERSEY MASS TORT (NON-ASBESTOS) RESOURCE BOOK 1 (2005), available at <http://www.judiciary.state.nj.us/mass-tort/masstortsopnonasbestos.pdf>.

310. Common Good, *supra* note 6.

311. Consider the following statistics. According to the Kaiser Family Foundation, there were 1061 paid medical malpractice claims in Pennsylvania in 2005. Kaiser Family Foundation, 50 State Comparisons: Number of Paid Medical Malpractice Claims, 2005, <http://www.statehealthfacts.org/cgi-bin/healthfacts.cgi?action=compare&category=Providers+%26+Service+Use&subcategory=Medical+Malpractice&topic=Paid+Medical+Malpractice+Claims> (last visited May 3, 2007). If one assumes a 27% plaintiff win rate, BUREAU OF JUSTICE STATISTICS, *supra* note 143, it can be estimated that Pennsylvanians litigated 3930 claims in 2005. While this crude hypothetical does not factor in the influx of lesser claims, *see supra* Section II.C, it suggests the inevitability of a clogged health court docket.



and, to some extent, controllable, in that the rate of claims filed remains stagnant from year to year.<sup>312</sup>

Despite the apparent disconnect between litigation trends and malpractice premiums,<sup>313</sup> there is evidence from over forty states with at least one statutory restriction on malpractice awards in the current tort scheme that premiums are lower with restrictions than without them.<sup>314</sup> Furthermore, a 2005 study on physician supply found “greater growth in physician supply in states that adopted reforms directly limiting liability than in states that did not.”<sup>315</sup> Tort reformers should not discount the relatively certain success that comes with reforming the traditional litigation scheme.<sup>316</sup> In contrast, the health court model limits individual liability while expanding collective liability, and its adoption would aggravate the impact of the next malpractice crisis. As such, tort reformers should focus their efforts on modifying the current system instead of spending federal dollars to experimentally implement an unproven new program.

In a 2003 report concluding that health courts were not the answer to Pennsylvania’s medical malpractice crisis, the Project on Medical Liability “suggest[ed] that procedural reform should focus instead on supporting the efforts of judges and juries to assess scientific and medical questions and on providing guidance for the award and review of noneconomic damages.”<sup>317</sup> To prevent the dueling-experts phenomenon, the report proposed imposing heightened standards for expert witnesses or encouraging judges to obtain expert testimony from neutral sources (for example, using empirical data to establish medical custom).<sup>318</sup> The report also mentioned methods for increasing consistency among noneconomic damage awards—including proposed statutory provisions that “would direct the judge to order remittitur if the judge determines that the jury’s award ‘deviates materially from what would be reasonable compensation’” and effectively lower the common “shocks the conscience” standard.<sup>319</sup> Although researchers have not yet studied the effects of these more modest reforms, their experimental implementation would cost substantially less than a health court test run.

With the Fair and Reliable Medical Justice Act sitting in committee following June 2006 hearings,<sup>320</sup> the medical malpractice reform debate has taken on new life. The potential for federal funding encourages states to tackle the malpractice crisis by implementing litigation alternatives, including health

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312. CONG. BUDGET OFFICE, *supra* note 18, at 4.

313. *See supra* notes 232-35 and accompanying text.

314. *Id.*

315. Kessler et al., *supra* note 220, at 2623.

316. *See, e.g., id.*; sources cited *supra* note 47.

317. *See* STRUVE, *supra* note 123, at 91.

318. *Id.* at 83-84.

319. *Id.* at 89.

320. *Medical Liability: New Ideals for Making the System Work Better for Patients: Hearing Before the S. Comm. on Health, Educ., Labor & Pensions*, 109th Cong. (2006).

courts. According to Howard, “We need . . . to make a compelling case that, one, the current system doesn’t work very well, and two, [the health court model] has a chance of working hopefully much better, and therefore we should try it out.”<sup>321</sup> Still, America has experienced malpractice crises twice before,<sup>322</sup> and Professor William Sage, a principal researcher for the Project on Medical Liability, cautions that “[t]oday we have to think about all the aspects of this problem before jumping to any solution.”<sup>323</sup>

The foremost concerns in this crisis are the cost of obtaining and providing health care, the efficiency of dispute resolution, and the equity of judgments. The proposal of health courts ambitiously attempts to solve all of those issues by carving out malpractice claims from the traditional litigation system and creating specialized tribunals of expert judges to hear them instead. By virtue of having lesser venues and no juries, state health courts could theoretically set forth a more consistent standard of care for physicians in less time with less cost. Implementing these courts, however, could lead to inequitable judgments, drive up transactional costs and malpractice premiums, and delay the resolution and compensation of victims’ claims.

Regardless of the variables that make up the malpractice crisis, when one third of a state’s surgeons leave in the span of eight years,<sup>324</sup> there is unquestionably a need for reform, and that reform should improve upon, rather than overhaul, the litigation system.<sup>325</sup> Pending the passage of the Fair and Reliable Medical Justice Act of 2005, states could soon be able to take advantage of federally funded grants to explore malpractice litigation alternatives. Despite having been touted as “a reliable system of medical justice” by its proponents,<sup>326</sup> health courts provide a very limited solution while potentially aggravating the current malpractice climate. Tort reformers should solve the problems of the current system by modifying it, instead of instigating an extreme makeover with uncertain and undesirable consequences.

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321. Eliasberg, *supra* note 33.

322. Sage, *supra* note 11, at 469-70.

323. Romano, *supra* note 25, at 28.

324. *Scalpel, Scissors, Lawyer*, *supra* note 67.

325. In 2005, thirty-two states enacted medical malpractice legislation, ranging from expert-witness qualifications to administrative procedures for the revocation of licenses from doctors who are repeatedly found guilty of medical malpractice. Nat’l Conference of State Legislatures, Medical Malpractice Tort Reform: 2005 Enacted Legislation in the States, <http://www.ncsl.org/standcomm/sclaw/medmalenacted2005.htm> (last visited May 3, 2007). Researchers could study the indoctrination of these varied state reforms to determine the optimal combination for resolving the problems associated with the malpractice crisis.

326. Common Good, *supra* note 6.

